

A five-year plan for mental health, developmental  
disabilities and substance abuse services



# BLUEPRINT FOR CHANGE

Division of  
Mental Health,  
Developmental  
Disabilities and  
Substance Abuse  
Services

State Plan 2002

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# EXECUTIVE SUMMARY

## INTRODUCTION

Reforming a statewide mental health, developmental disabilities and substance abuse system is an evolving, dynamic process that unfolds while the system performs its regular tasks. This presents opportunities for course corrections along the way. Re-evaluating the established, traditional processes of the system, piloting selected elements and hearing the observations and concerns of consumers, families, advocates and professionals provides valuable opportunities to see in real-life and real-time things that are likely to work well and those that still need to be adjusted, refined, and thought through.

This is the first annual revision of the NC Department of Health and Human Services (Department) *State Plan 2001: Blueprint for Change*. The focus of the revision is on clarifying issues, fleshing out details, responding to concerns and reporting progress made since the State Plan's original publication. The major concepts included in the original version, December 2001, are unchanged. Realigning the state's sizable investment in services for mental health, developmental disabilities and substance abuse from one of excessive reliance on institution/facility care to a community-based system that helps people with disabilities live normal lives in natural communities continues to be at the forefront of the reform effort.

*The State Plan is designed to change over time. Each spring, there will be a public comment period, and a revised version will be published each July.*

This revision includes new and expanded material. The revised State Plan is arranged into five chapters, followed by separate technical documents describing business plans for both state and local service systems, an overview of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (Division) reorganization, staff competencies and the March 2002 quarterly report to the Legislative Oversight Committee (LOC).

## ACKNOWLEDGMENTS

The Department and the Division want to extend our appreciation and gratitude to the members of the LOC for their continuing support and help in communicating this reform to everyone. They have been steadfast in their dedication and commitment to a new system, devoting many hours and hundreds of miles making sure that reform efforts are communicated statewide. We also want to say a sincere and heartfelt "Thank You" to all of our public and private partners who have taken up the challenges of reform and come forward to work with us to make the new system a reality.

Many of the changes in this revision were derived from stakeholder feedback. Since the original State Plan was released, Division leadership and the Division project team have evaluated hundreds of observations, recommendations, and expressions of concern from county governments, area programs, providers, advocates, consumers and families across the state. Feedback received in writing during the public review period that ended on April 19<sup>th</sup> will be available for review on the Department web site at: <http://www.dhhs.state.nc.us/mhplan/>. The main, recurring themes of concern and/or suggestions are these:

**Consumer involvement – *People the system serves must be involved at every level and given opportunities for meaningful participation including mentoring, training and genuine welcome.*** A critical measure of system performance at both state and local levels will hinge on the extent to which this message is consistently heard and acted upon.

**Target populations – *The populations defined in the State Plan will eliminate many people who are now receiving services.*** It is true that some people who currently receive services now will need to seek them elsewhere. However, this will be part of a transition process. The LMEs are responsible for developing a range of both paid and volunteer services in each region to which people with less severe needs may be referred. The revised description of target populations in this document should better clarify eligibility requirements.

**Services/supports - *Not enough private providers especially in rural areas; possible disruption or reduction of services; downsizing facilities before community services/ supports are developed; attention to people with multiple disabilities; access to services; adequate housing and transportation.*** It is known

*“As a psychiatrist who worked in the community in a rural community mental health center with very good leadership, I am aware that services are hard to obtain in more rural areas.”*  
State Plan feedback

that rural areas may lack sufficient provider resources, particularly at the start of the reformed system. For that reason, and to prevent any reduction or disruption of services, there is a provision that, pending development of an adequate private network, LMEs may request to directly provide services that are currently unavailable in their regions. Chapter 2 contains information on the progress of the Olmstead Plan, regional development of community capacity and the Division’s direct oversight and monitoring of people who are returning to communities from facilities. People with multiple disabilities are part of every disability group’s target populations and will be a specific focus of the Division’s cross-disability approach. Local business plans must assure that network providers are accessible within stated mile/minute limits and that a range of housing options and voucher systems for transportation assistance is available.

**Financial Concerns – *Not enough funding for reform; money saved from downsizing institutions will not follow individuals to the community; reimbursements for direct services billed to LMEs too slow.*** The Department and Division position is that there is not enough funding to **not** reform. The system must use its limited resources for those with the most

serious needs, and it must meet those needs in the most effective and efficient ways possible. Chapter 5 includes new information about system financing. The Division recognizes that reimbursement to providers is an issue. Because of that, claims management is an element in local business plans and in the performance of the LME.

**Transition – *Transition must be gradual; services not reduced or disrupted; people need to be supported through the transition; what happens to area program clinical staff.*** Chapter 5 includes a discussion of transition issues as well as guidelines for LMEs divesting direct services, including *spin-outs* and *spin-offs*.

*“...the Plan  
recognizes the finite  
resources of the  
state ”  
State Plan feedback*

**Details – *Questions about the how, when, where.*** This revision contains much more detail than the original version, as will each succeeding revision. Information can be gathered throughout the year by following the quarterly reports to the LOC and visiting the Department web site.

Reforming large and complicated systems is always a work in progress. Comments and suggestions received have been enormously helpful in moving the system closer to reform. We hope that this revision will answer many of the questions and concerns that have risen over the past eight months and look forward to continued feedback.

## MAJOR PROGRESS POINTS

Progress toward reform is moving forward on several fronts. County governments, area programs, providers and advocates have accepted the challenges of reform, working together with the state to determine how best to bring the vision of a new system into reality. These activities are briefly described here.

### New Division leadership and re-organization

Richard Visingardi, Ph.D., was appointed director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services on February 4, 2002. Dr. Visingardi has a broad background of services/supports to people with disabilities, both as a provider and administrator, in both large and small geographic areas. His previous experience in major system change will provide a sure-footed path toward implementing reform in North Carolina over the coming years. A good deal of the new material in this revision bears the imprint of his knowledge, enthusiasm and dedication to helping people with disabilities build meaningful and satisfying lives.

The Division is being reorganized to more directly support and facilitate system reform. The traditional Division model segregated operational units into essentially freestanding, single-disability *silos*. (This term is used to describe an agency or part of an agency that operates on its own

without collaborating or communicating with others.) It is being replaced with a more functional, cross-disability framework that fosters and encourages development of common approaches to the same or similar issues. This is not generic one-size-fits-all but, rather, a recognition that the expertise and resolution of problems in one specialty area often have application and value in the others as well. It builds an integrated, consistent organization that speaks more inclusively and with one voice. Just as area programs are struggling to transform their organizations from one of community service provider to that of public agency manager, Division staff will need to develop broader leadership perspectives and new and different sets of skills in order to meet the challenges and demands of working within a new structure and professional era.

A description of the main structure of the Division reorganization is included in this revision as a technical document. Further details of the tasks, functions and duties of each operational element will be developed by Division leadership over the next few months, with full implementation to take place between October 2002 and January 2003.

### **Implementation activities**

***Spreading the word about system reform:*** Division staff have traveled over the state, presenting the major points contained in the State Plan to county commissioners, board members, area programs, private providers, consumers and their families, other public and private agencies and numerous stakeholder groups. These meetings and presentations will continue as long as they are needed. Interested people throughout the state have had an opportunity to become familiar with the main concepts of system reform, and the focus of communication has shifted toward the more technical aspects of implementation.

*“Implementation must be done, not just written. This is very, very challenging.”  
State Plan feedback*

***Implementation structure:*** Since the publication of the State Plan, the Division has formed three implementation committees to oversee and guide the reform effort. These oversight committees are composed of Division staff, one or more consumers or family members and various stakeholders. The committees are focused on issues of: a) access, program development and new initiatives; b) quality of care and quality improvement and c) administration and infrastructure. (See appendix for lists of people participating in these groups.)

Each committee has a number of workgroups developing specific elements of the State Plan. Members of workgroups are drawn from a wide spectrum of area program staff, providers, consumers, families and advocates. Details about implementation activities and progress can be found in the technical document describing the state strategic business plan. Additional information about implementation is contained in the March 2002 system reform quarterly report to the Legislative Oversight Committee (LOC), included in this revision. Reports and other information about the

State Plan and its implementation are also posted on the Department web site at: <http://www.dhhs.state.nc.us/mhplan/>. Division reorganization will change the current implementation structure as the work of system reform becomes the hub of the newly organized Division.

***Involvement of consumers and families in implementation:*** Consumers and families are active participants in the implementation process, with representation on each committee and nearly all workgroups. Three workgroups are composed entirely of 21 consumers and family members and staffed by Division personnel. Their areas of work are: a) consumer and family participation in system improvement; b) providing advice related to the consumer advocacy program contained in the reform statute and c) studying revisions that need to be made in client rights and appeals rules.

A database of consumers and families willing to serve voluntarily on implementation workgroups has been developed and shows representation from across the state. These volunteers include 66 consumers (28 mental health consumers, 28 consumers with developmental disabilities, three substance abuse consumers and six consumers with co-occurring disabilities) and 84 family members of adult and child consumers from among all disability areas. Consumers are paid a daily stipend and reimbursed for the expenses of their participation.

*“Let people live their own lives by supporting their choices, but not controlling them.”  
State Plan feedback*

Feedback from consumers and families over the past eight months continues to repeat a concern that neither the state nor local systems will provide opportunities for people with disabilities to participate meaningfully and authentically in the reformed system. The State Plan requires major consumer involvement – at the individual level and the systems level, in development of local business plans and at the LME operations level. Involvement of people with disabilities and their families should, at minimum:

- Be valued and meaningful.
- Include initial orientation and ongoing development.
- Include provisions for individualized support and accommodation.
- Include an initial and ongoing dialogue regarding roles, responsibilities and expectations for all parties.
- Embrace diverse disability and cultural perspectives in systems design and problem solving efforts.
- Include methods for incorporating systems improvements and organization cultural changes reflective of what is learned from people with disabilities and their families.

***First phase-in and demonstration/piloting of system reform elements:*** Over the past seven months, a number of area programs have been designated by their counties to become the new system’s local management entity (LME). Most of those designated are moving forward with planning and developing local business plans. Some are participating in a first phase-in of the new

system and will demonstrate or model various aspects of the Plan as a learning and testing tool for eventual statewide implementation. Read more about this in the revised chapter 2.

## REVISION HIGHLIGHTS IN BRIEF:

Major changes included in this revision are presented here as a brief orientation to the new and expanded chapters and as a convenience for locating revised sections. The revised State Plan is comprised of the main plan document, consisting of five chapters. These are followed by technical documents on state strategic business plan, local business plan, Division reorganization, plan for staff competencies, and the March 2002 quarterly report to the Legislative Oversight Committee (LOC) on the state's progress toward system reform. The following is a brief synopsis of chapter and section contents.

### Chapter 1: Foundations of reform

This chapter includes a review of key developments in legal and social policy toward people with disabilities that have formed the basis and established the direction for state efforts to reform their mental health, developmental disabilities and substance abuse service systems. These policy changes, together with advances in knowledge, treatment, services and supports make it possible to develop a service system that both acknowledges and honors the right of people with disabilities to live more normal lives in natural communities of their choice.

*"The State Plan requires that everyone work together to build a new & better system....it just needs to be adhered to."  
State Plan feedback*

### Chapter 2: Changes in the current system

This chapter provides an update of major progress toward implementation. The Division has received many messages of concern about the need to build community services before closing hospital beds. This chapter includes information on community capacity enhancements that are underway, an update on the Olmstead implementation initiative and specific measures being taken to monitor the wellbeing of people who return to communities to live. There is also a discussion of the hospital consolidation plan and progress toward expanding services within Alcohol and Drug Abuse Treatment Centers (ADATCs) intended to

divert unnecessary admissions to psychiatric hospitals. Finally, there is a report on counties' selection of their LMEs and also plans for a first phase-in of some LMEs to the new, reformed system. More detail on implementation can be found in quarterly reports to the LOC and on the Department web site.

### Chapter 3: Designing a new system

The contents of this chapter are intended to provide more detail and answer questions and concerns received since the original publication of the State Plan.



*Core functions* as used in the reform statute and the State Plan are often misinterpreted to mean the minimum, basic set of services that must be available in each region. Medication management is one example. However, core functions are best thought of as access pathways into the reformed system, closely connected with the concept of *uniform portal*.

The description of a *statewide system contractor* has been slightly revised. The contractor will provide 24-hour telephone information and referral, with the capacity to connect callers directly with the LME or the local emergency system in each region. Area programs currently contracting for local or out-of-state 800 number referral services will not be funded to duplicate that expense. The contractor will also provide utilization management and prior authorization for high-cost services such as acute inpatient hospitalization, long-term residential/facility placement or, eventually, approval of an entire person-centered plan when expenditure levels exceed a funding trigger point. This contracted service does not function as the referral hub for the statewide system or the collection point for system-wide data other than utilization of high-end services and the number, content and disposition of 800 number calls. All other local utilization management shall be performed by the LME following statewide criteria established by the state.

The description of *target populations* has been expanded to give more detail about determining eligibility for publicly funded services in the new system. The description of adult mental health target populations now includes a list of diagnostic categories covered under severe mental illness (SMI). The description of child mental health target populations has been clarified to focus primarily on children who are severely and moderately emotionally disturbed. The descriptions of target populations for substance abuse services and developmental disabilities remain essentially unchanged.

*“We, as a community, need to work on this together - volunteer groups, private providers, area programs, church groups - to build a more caring community that is sensitive to consumer needs. It’s called ‘community mental health’ for a reason.”*  
State Plan feedback

## **Chapter 4: Responding to the needs of people with disabilities**

This chapter defines critical elements that are vital to the reformed system whether responding to the needs of a single individual, or building a system designed to meet the needs of thousands of people. It describes some of the philosophical and theoretical frameworks underlying best practice models that result in positive outcomes for people and sets out principles that, once internalized and matured, become the foundation underlying all system operations and functions, among all disabilities and age groups. The structural system reforms embodied in concepts such as LMEs, target populations, regional consolidations and qualified provider networks, present dramatic, visible changes that instantly capture the attention of those eager for change and those resistant to it. Equally important, but perhaps less obvious, are the reforms needed in *how* we support people with disabilities. The *how* relates to the ways the system applies best practice models to achieve positive outcomes for the people it serves and involves acquiring and applying new knowledge and gaining experience in its use and value. *How* the system supports people is



rooted directly in the attitude/approach of system agents, whether public or private, provider or manager and indirectly in every other system that touches and intersects with this one. In other words, it requires a change in system culture. The success of the mission, guiding principles and vision of the State Plan ultimately depends on this culture change.

## **Chapter 5: Management and administration**

This new chapter covers issues around system structure and organization, management and decision support infrastructure at both state and local levels. There is a broader discussion of individual and system transition issues, guidelines for LMEs divesting services and issues related to network membership and contracting for services and programs.

There is additional information on the LME as direct provider of services in areas in which there is a service provider shortage. One notable change: LMEs who are authorized to provide direct services must obtain external case management for the services they provide, with the single exception of psychiatric medication management.

*The discussion of Department coordination and infrastructure* responds to the many requests for more information on how the state intends to improve its own performance in the reformed system. This section describes the major initiatives that are currently underway to strengthen the Division's leadership capacity and to improve its business processes.

*Financing* includes more details on strategies for funding the new, reformed system and describes cost modeling projects that are currently underway.

## **Technical documents appended to the revision**

### ***State strategic business plan***

The business plan timeline, previously in chapter 3 of the original State Plan, and the state business plan, formerly in separate sections, have been expanded and combined to coincide with revised requirements for local business plans. This document stems partly from feedback requests for more detail on reforms and improvements at the Division and Department level. It provides information on tasks and strategies, outcomes and products and gives a timeline for accomplishing these tasks. As the Division transitions into its reorganized structure, the state strategic business plan will be revised again to reflect the changes. Updates will be posted on the web and included in the quarterly reports.

### ***Requirements for local business plans***

The document on local business plans has been substantially rewritten for ease of understanding and clarification of major issues. It contains general information and forms to be completed in the local business plan process. Also included is a tool for scoring local business plan submissions. It is incorporated here so that local planners can see in advance what the state will be using to evaluate

plans for certification. Initial sections of the proposed local business plan must be submitted by January 2, 2003, and the plan completed by April 1, 2003. Local system planners may choose phase-in periods corresponding to stated six-month intervals. Regardless of the selected phase-in date, every local business plan is expected to provide detailed information on progress toward full implementation of LME functions and an adequate local service system.

### ***Division re-organization***

The document gives an overview of the Division's reorganization. The reorganization is designed to support and facilitate system reform. The document briefly describes the new organizational structure and principal areas of responsibility for executive leadership and functional teams. One of the primary objectives of the reorganization is to establish system reform, with all of its attendant efforts and activities, as the central core of the organization around which all goals and actions revolve and to which the sum and value of all effort must return. The executive leadership group will be recruited/selected by July 1, 2002. This group, with the director and deputy director, will recruit/select management team leaders. Together, and with wide input and consultation, they will develop the details by analyzing the functions, cross-walking all of the tasks and determining numbers and types of staff and sets of skills needed. The reorganization is to be fully implemented sometime between October 2002 and January 2003.

### ***Staff competencies***

This document includes only minor revisions from the original State Plan.

### ***Quarterly Reports***

The reform statute contains a provision requiring quarterly reports to the LOC on the progress toward system reform. The first report was submitted in March 2002 and is included as a technical document in this revision. The next report is due July 30<sup>th</sup>. It and subsequent reports will accompany each annual revision of the State Plan and will be posted on the web.

*"The State Plan is all encompassing in its reform effort, and some prioritization is needed as to the relevant order of the change process." State Plan feedback*



## Chapter 1: Foundations of Reform

### INTRODUCTION AND OVERVIEW

*State Plan 2001: Blueprint for Change* initiated the first major reform of North Carolina's mental health, developmental disabilities and substance abuse (mh/dd/sa) services system in more than thirty years. The State Plan was developed in response to the passage of Session Law 2001-437 that called for sweeping reforms in the service system over a five-year period. Carmen Hooker Odom, secretary of the NC Department of Health and Human Services, initiated the State Plan to return North Carolina to its once proud level of distinction, one that includes a system demonstrating compliance with federal and state rules and expectations. This is the first annual revision.

The main concepts contained in the State Plan's original version are unchanged. Focusing the state's limited resources on those who are severely disabled continues as the central theme. This revision incorporates recommendations received from system stakeholders over the past months, provides detail on certain issues and clarifies previous areas of confusion.

Most people are aware of the reasons for the system reform movement in North Carolina. They agree that reform, though difficult, is necessary in order to reclaim the exemplary heritage that once characterized North Carolina's services to people with disabilities. There is some distance, however, between knowing that change must occur and moving forward to bring about reform.

There may be as many perspectives and viewpoints on what the mh/dd/sa system should look like as there are people who have interest in them. Consensus, then, becomes the major focus and challenge in finding the right road and in making the journey.

*Major developments  
in national policy  
have laid the  
foundation for state  
reform efforts and  
informed the shape  
and design of  
modern systems."*

### Which way, and to where?

This chapter includes a review of the recent major developments in legal and social policy that indicate direction the states as they work toward reform. Evaluating growing trends in policy may also provide valuable hints about potential pitfalls to avoid. As public policy evolves over time, it creates the framework on which service systems are built and establishes the community context of daily life for people with disabilities. Key policy changes over recent decades, together with ad-

vances in treatment, services and supports, are reshaping the profile and design of contemporary public systems.

Much of the underlying basis for policy shifts over the last forty or fifty years stems from legal and ethical concerns about the proper role of government in the personal lives of private citizens. With regard to adults with mental illness, for example, key policy issue has focused on deprivation of rights to *due process* and of personal liberty. It is a loss of freedom to impose restrictions or control on a person if that person does not have an opportunity to dispute what is being done. These fundamental freedom concerns have led to reforms in civil commitment requirements (*due process* considerations) and alternatives to more restrictive treatments and settings. The continued debate grapples with the relative balance between the inherent freedoms afforded each individual citizen and the restrictions or controls imposed on individuals who have mental health conditions that may inhibit their judgement in a manner that would unintentionally bring harm to themselves and/or others.

Civil liberty concerns are also the focal point of continued policy debates regarding adults with developmental disabilities; however, these issues are primarily targeted toward a desire to protect these individuals from harm. Evolving policy in this area has been strongly influenced by innovative community-based support-oriented models of practice. As the community's ability to support and accommodate these individuals advances, the boundaries of *reasonable risk* expand, and people with developmental disabilities are afforded new opportunities for natural community life.

As minors, children with severe emotional disturbances have limited rights and voice. Policy developments have been greatly influenced by a *best interest* perspective; that is, whatever is in the best interest of the child. Most recently, the *best interest* debate has been shaped largely by concerns regarding stabilization of life domains (family, school and friends). A child has limited and fragile life domains. Policy efforts have focused on developing a range of flexible supports that are best delivered within the life environment of the child, including adequate safeguards and alternatives where health and safety issues are a valid concern. Additionally, policy has encouraged systems collaboration as a means to create a *seamless* and more responsive mechanism to address child and family needs.

Sometimes, solutions to troubling policy questions begin with grassroots efforts to help oneself and others. The modern view of alcoholism arose in response to the traditional view of the alcoholic as a person of poor moral character whose treatment was relegated to city *drunk tanks*, wards of public hospitals, or the back wards of aging and deteriorating state psychiatric hospitals. Sometimes alcoholics were sent to local jails. The birth of modern substance abuse treatment began with the creation of Alcoholics Anonymous (AA) by Bill W. and Dr. Bob in 1935. This movement was based on the premise that a recovering alcoholic could assist in the recovery of another alcoholic through personal fellowship, support and sponsorship. This early beginning evolved into a treat-

ment movement in the 1970's and 1980's that established a national network of professional addiction treatment services.

Research has shown that drug abuse treatment is both clinically effective and cost effective in reducing drug consumption, *and* also the associated health and social consequences that characterize addiction. Treatment gains are typically found in reduced intravenous and other drug use, reduced criminality and enhanced health and productivity. Yet today, at the cultural and social policy level, there is growing evidence that, despite the proven success of treatment services, alcoholism and other addictions are being *de-medicalized*, *re-stigmatized* and *re-criminalized*. Care and treatment of alcoholics and addicts is once again shifting toward punishment and control in the criminal justice system. Recovering people constitute one of the largest and most invisible communities in America, and they are beginning to reassert themselves as a teaching and healing force.

## CHANGING TIMES

These key issues have been at the center of the policy debates and program/service developments over recent decades. Our general struggle as a democratic society has revolved around efforts to reconcile social justice and economic concerns. Although this struggle occurs in tandem with every public policy effort, each has enjoyed a particular dominance.

### **Social justice era: policy formulation and implementation**

Social justice was a dominant force from the mid-1950s through 1980. All three branches of the federal government worked in concert to form a new value/attitude toward people with disabilities. The civil rights and anti-poverty efforts of Congress resulted in statutes recognizing citizens suffering discrimination as well as creating financing programs for the poor such as Medicaid. The Community Mental Health Facilities Construction Act created opportunities for states to move toward community-based systems of care and programs. Simultaneously, the judicial branch strongly influenced community-based development in landmark cases citing poor conditions in many large institutional settings. Future protections from such conditions were advanced through efforts such as passage of the Civil Rights of Institutionalized Persons Act (CRIPA).

This time period also saw the advancement of *due process* protections against arbitrary denial of entitlements (Goldberg vs. Kelly) and increased demands for public systems to operate in the *light of day* (specifically, Administrative Procedures Act, Freedom of Information Act and Open Meetings Act).

*“ We envision a society where people who are addicted to alcohol and other drugs, people in recovery from addiction and people at risk for addiction are valued and treated with dignity; and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. We envision a society where addiction is recognized as a public health issue - a treatable disease for which individuals should seek and receive treatment; and where treatment is recognized as a specific field of expertise.”*  
a recovery advocate,  
Changing the Conversation,  
November, 2000

Focus of the *social justice era* was to protect the civil rights of each individual and to establish the societal equality of people with disabilities. Two major criticisms of the time centered around whether these policies were actually working as they were intended and how to manage the spiraling expenditures of these policy efforts when public revenue strategies were in question.

### **Economic efficiency era: policy management and accountability**

These concerns ushered in a policy shift in the 1980's to deal with issues of economic efficiency – policy management and accountability. Direct fiscal changes began to occur in tax policy, revenue sharing and indexing (virtually automatic cost increases for programs), as well as indirect changes such as increasing deregulation and alternative methods to organize public policy.

Comparisons between publicly operated systems and those that are wholly privatized have shown that each has its relative merits and benefits, but neither model, taken alone, produces satisfactory results. Therefore, continuing developments in policy have focused on the *best mix*. These approaches clearly identify that, for the populations we serve, public entities at the state and local levels are designed to ensure *public accountability*, while community organizations are designed to ensure *provision of services*.

### **Disability rights to rights of full citizenship**

The concepts of social justice and economic efficiency are often posed as polar opposites. However, advancements in the disability movement would suggest that they could actually work together. Initial responses to the adverse treatment of people with disabilities created the disability rights movement. Most of these efforts resulted in protections for what some may define as *special people*. However, over the past ten to twenty years we have experienced a transformation from the

disability rights era to an era of full citizenship. The collective efforts of those concerned with social justice have resulted in the enactment of statutes (i.e., Americans with Disabilities Act, Individuals with Disabilities Education Act, revisions to the Rehabilitation Act, the Fair Housing Act) and court decisions (i.e., Olmstead) that have a common theme – *people with disabilities are full citizens and should be afforded opportunities like all citizens*.

*“Families & consumers need to have meaningful roles in the planning & decision-making. The local plan should include...what measures were taken to educate families & consumers about the process & community options.”*  
State Plan feedback

### **CHANGING PEOPLE'S COMMUNITY LIFE**

Policies toward people with disabilities establish the context in which they live. Over recent decades there has been a shift, moving from dependency to independent living and, finally to inter-dependence.



## Dependency

The dependency perspective stems from a long-held belief that the lives of people with disabilities were best placed in the hands of others who would make decisions for them for their own protection. At the height of the institutional era, more than 500,000 people were living involuntarily in these constantly impoverished institutions, dependent on government for every meal and article of clothing.

## Independence

The independence perspective grew out of the civil rights movement. Renewed debate about the nature and causes of mental illness coupled with strong denunciation of long-term detention for people who had committed no crime, forced a wrenching shift in policy that had far-reaching, serious consequences. Thousands of people streamed out of state hospitals. Federal funding programs to build local clinics and provide personal income were intended to support community-based treatment. But several things happened: 1) many people exercised their new found independence and failed or refused to get the help available, 2) over time funding for these programs slowly dissipated and 3) perhaps most important - at that time the system did not know *how* to effectively support people with disabilities in communities.

## Interdependent

The unsatisfactory outcomes of the independence era lead to a new examination of meaningful community life. Observers began to focus on the interconnected nature of supports, services and treatment. This includes, reciprocal relationships with other people, places and things and the natural human tendency to acquire resources within the interconnected world that make life safe, meaningful, and satisfying. This realization paved the way to a whole new universe of possible methods and technologies that recognize and help people acquire the life supports required for living a full and rich life of choices and opportunities.

Although there was a very rough start, the evolution of public policy over recent years, coupled with advancements in knowledge, treatment, services and supports, now make it possible to develop a service system for people with disabilities that both acknowledges and honors their right to live in natural communities of their choice.

The mission, values and principles of the State Plan guide and inform North Carolina's reform effort through the great changes ahead and tell us when we have achieved success. The road may be long, the journey will be hard, but the destination is in sight.

## MISSION, PRINCIPLES, VISION

### Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary, prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

### Guiding Principles

Treatment, services and supports to individuals and their families shall be appropriate to needs, accessible and timely, consumer-driven, outcome oriented, culturally and age appropriate, built on individual strengths, cost effective and reflect best practices.

Research, education and prevention programs lower the prevalence of mental illness, developmental disabilities and substance abuse; reduce the impact or stigma; and lead to earlier intervention and improved treatment.

Services should be provided in the most integrated community setting suitable to the needs and preferences of the individual and planned in partnership with the individual and/or family.

Individuals should receive the services needed based on a person-centered plan and in consideration of any legal restrictions, varying levels of disability, and fair and equitable distribution of system resources.

System professionals will work with individuals and their families to help them get the most from services.

Services shall meet measurable standards of safety, quality and clinical effectiveness at all levels of the mental health, developmental disabilities and substance abuse system and shall demonstrate a dedication to excellence through adoption of a program for continuous quality improvement.

All components of the mental health, developmental disability and substance abuse system shall operate efficiently.

### Vision

Public and social policy toward people with disabilities will be respectful, fair and recognize the need to assist all that need help.

The state's service system for persons with mental illness, developmental disabilities and substance abuse problems will have adequate, stable funding.

System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

All human services agencies that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.

Consumers will have:

- Meaningful input into the design and planning of the service system.
- Information about services, how to access them and how to voice complaints.
- Opportunities for employment in the system.
- Easy, immediate access to appropriate services.
- Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life.
- Safe and humane living conditions in communities of their choice.
- Reduced involvement with the justice system.
- Services that prevent and resolve crises.
- Opportunities to participate in community life, to pursue relationships with others and to make choices that enhance their productivity, well being and quality of life.
- Satisfaction with the quality and quantity of services.
- Access to an orderly, fair and timely system of arbitration and resolution.

Providers and managers will have:

- Opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components.
- Access to an orderly, fair and timely system of arbitration and resolution.
- Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided and that contain only those elements necessary to substantiate specific outcomes required.
- Training in services that are proven.

## MANAGING THE CHALLENGES OF CHANGE

The original release of *State Plan 2001: Blueprint for Change* has raised some challenges and obstacles that need to be addressed and overcome in order to take the next steps. Adopting some overarching goals that guide the process helps to keep us on track toward the system envisioned in the State Plan.

**Investing for success** presents an initial challenge for state and local systems in determining how best to manage finite resources to respond to what seems to be infinite need. To begin, we need to look very closely at whom we support and serve, as well as the manner in which we support and serve them. Consistent with the principle that government assistance is limited to

***“Investing for Success – The wise use of resources requires investment in prevention, treatment, services and supports that, in turn, produce the desired results.***

***No Wrong Door to Prevention and Treatment – Effective systems must ensure that an individual needing prevention, treatment, services and supports will be identified and assessed and will receive services either directly or through appropriate referral, no matter where he or she enters the realm of services.***

***Commit to Quality – Effective prevention, supports, treatment and services and the wise use of resources depend on ongoing improvement in the quality of care.***

***Change Attitudes – Significant reductions in stigma and changes in attitudes will require a concerted effort based on systematic research.***

***Build Partnerships – Effective efforts by individuals and organizations throughout the system to work with each other and with the many other people and groups throughout the state who share a concern to improve treatment, prevention, services and supports will require specific encouragement and support.”***

*Changing the Conversation, CSAT, 2002 (federal Center for Substance Abuse Treatment)*

those who are most in need, the target populations in the reformed system are those people with the most severe disabilities.

**Managing finite resources** also requires that we apply the best and emerging best practices that have resulted in positive outcomes for people. Services that fail to render real life outcomes for people need to be discontinued. Second, there should be appropriate transition plans for people with disabilities who can be served in their communities but are currently in state facilities. These people should live and receive services/supports in their communities. There is also a valid concern

that some people with lower levels of need will require services from elsewhere in the community. Part of the community planning process involves looking to the community – including faith-based organizations and grassroots agencies to develop responses for all citizens in need.

**No Wrong Door** requires many avenues of access where people can enter the system, and it also speaks to the need for a customer-service oriented approach that shows a genuine desire to help those who enter. The concept of *uniform portal*, described later in this document, establishes the expectation of a consistent statewide process for entering and leaving the public service system that supports and facilitates access to services no matter where the person enters.

**Commit to Quality** means we take up the challenge of continuous quality improvement. We make the best use of information available to us to help appraise our performance, measure outcomes and look constantly for opportunities to do things better. If this means breaking with a tradition that honest evaluation tells us is not effective, then we must abandon that tradition and find something that does work.

**Change Attitudes** applies across the board. It means that we work on issues of community inclusion and capacity development for people with disabilities recognizing and honoring their right to full citizenship in communities of their choice. It means that we listen carefully to the experiences and observations of the people we serve; they have a view of the system that most of us never see. For some of us, it means loosening our grip on a present that is now the past and reaching out to embrace the promise of the future.

**Building Partnerships** is to recognize the unique strengths and talents that are already present throughout the system and to gather them into an integrated, synergistic whole in which each contributes its best, and the total has greater value than the sum of any of its parts.

*“The State Plan should not be a system of menus and programs, but a system of support for consumers and their families and to those in the community, healthy or dependent.”*  
State Plan feedback



## Chapter 2: Changes in the Current System

State Plan implementation has become the central, overarching priority of the Division and all of its components. The Division has a strong, visionary leader in Dr. Richard Visingardi, experienced in managing the challenges and avoiding the pitfalls, of large system reform. A reorganization of the Division that more fully supports and facilitates the State Plan has been developed for gradual implementation. More information about the reorganization is included as a technical document.

Eight months after the release of *State Plan 2001: Blueprint for Change*, active movement toward reform is already changing the landscape of the current system. Citizens in the state have heard about the State Plan either directly from state staff, in local forums, through newspaper articles or at the Department web site. Information sharing at this point is moving beyond presentation of the State Plan's basic concepts and on toward the more technical and complicated tasks of implementation.

Stakeholders at every level - state, counties, LMEs, providers, consumers, families and advocates - are working together to make the system envisioned in the State Plan a reality. Many are donating hundreds of hours in workgroups and committees convened to develop the details of reform components. Additionally, the Division receives many messages of support, areas of concern, extremely valuable suggestions and recommendations for implementation from system stakeholders around the state. Each of these is studied and considered for possible inclusion. The experience and expertise that these observations bring to the reform process are enormously helpful.

System change is underway at the local level. County governments have explored options for merger with other counties and decided on their preferred governance model. Letters of intent from county commissioners are being received. A significant number of area programs have requested to be considered as part of the first phase in becoming an LME in the new system. Most of the area programs that currently serve these counties will be among the first group to assume their new role as LMEs and phase in the new system. Some have proposed to pilot or model various components of the State Plan as learning and testing tools for eventual statewide implementation. The Division is reviewing these requests on a case-by-case basis. A list of these counties and area programs (LMEs) as of June 17, 2002 is displayed below:



Area Program	Counties	Consolidation
CenterPoint Human Services	Davie, Forsyth and Stokes	
Pathways Mental Health, Developmental Disabilities & Substance Abuse	Gaston, Lincoln and Cleveland	
Mecklenburg	Mecklenburg	
Albemarle Mental Health Center & Developmental Disabilities & Substance Abuse Services	Camden, Chowan, Currituck, Dare, and Pasquotank	Pending
Roanoke Chowan Human Services Center	Bertie, Gates, Hertford and Northampton	
Piedmont Mental Health, Developmental Disabilities & Substance Abuse Services	Cabarrus, Rowan, Stanly and Union	
VGFW Area Authority	Vance, Granville, Franklin and Warren	
Duplin-Sampson Mental Health, Developmental Disabilities & Substance Abuse Services	Duplin and Sampson	
Wayne County Mental Health Center	Wayne	Pending
Lenoir County Mental Health, Developmental Disabilities & Substance Abuse Center	Lenoir	
Smoky Mountain Center for Mental Health, Developmental Disabilities & Substance Abuse Services	Cherokee, Clay, Graham, Haywood, Jackson, Macon and Swain	
Blue Ridge Center for Mental Health, Developmental Disabilities & Substance Abuse Services	Buncombe, Madison, Mitchell and Yancey	Pending
Trend Area Mental Health, Developmental Disabilities & Substance Abuse Authority	Henderson and Transylvania	
Rutherford-Polk Area Mental Health Developmental Disabilities & Substance Abuse Authority	Rutherford and Polk Counties	
Edgecombe-Nash Mental Health, Developmental Disabilities & Substance Abuse Services	Edgecombe and Nash Counties	Pending
Halifax	Single county	
Wilson-Greene Area Mental Health, Mental Retardation, & Substance Abuse Services	Wilson and Greene	
O-P-C Mental Health Developmental Disabilities & Substance Abuse Authority	Orange, Person and Chatham	
Wake County Human Services	Single county	
New River Behavioral HealthCare	Alleghany, Ashe, Avery, Wilkes and Watauga	
Neuse Center Mental Health, Mental Retardation, & Substance Abuse Services	Carteret, Craven, Jones and Pamlico	

## SERVICES AND PROGRAMS

Building a system of supports, treatment and services for people with disabilities that makes it possible for them to live meaningful and satisfying lives in communities of their choice is a gradual process influenced by many considerations. Progress needs to occur on a number of fronts simultaneously, such as building infrastructure, developing community capacity and acquiring skills needed to apply best practice models that are shown to result in positive outcomes for people. The changing system must also continue to provide needed services to people without interruption during the change process and support them through transition periods. First steps toward the community-based system called for in the State Plan are reducing system reliance on institution/facility care and moving to a person-centered support and treatment approach.

### Community service expansion

Planning groups, consisting of area program and Division staff, have met throughout the state's geographic regions to generate service expansion plans. For state hospitals, regional planning groups have determined the type and number of hospital beds slated for closing and identified the types of treatment, services and supports needed in communities to sustain and support individuals out of state hospitals. These may include key service elements such as Assertive Community Treatment Teams (ACTT), supported housing, transportation, medication management, psychosocial rehabilitation, case management and others. Ultimately, expansion plans need to specify what services are needed, when they will be implemented (prior to the specified bed closures) and at what cost. Similar work is going on regarding the state children's residential programs and mental retardation centers.

Much of the current work on building community capacity is occurring in connection with the Olmstead Plan initiative. Individuals who have been hospitalized longer than 60 days have received Olmstead assessments and personal preference interviews. Further information on specialty service and support needs are being gathered from hospital social work and treatment staff and area program personnel. Area program, hospital and Division staff is working on improved guidelines to ensure that there is a high degree of collaboration between the state and local service systems on discharge planning.

### Downsizing activities

By the end of June 2002, the mission of the state psychiatric hospitals will have begun to narrow, consistent with the State Plan. The certified nursing facility service units at Broughton and John Umstead hospitals have been eliminated, and the one at Cherry Hospital reduced. The individuals cared for in these units have been transferred to community nursing facilities where necessary capacity was already in place.

The Wright Transitions program at Dorothea Dix Hospital will close by June 30, 2002. At the time that funding was allocated to expand community services, there were 27 people being served by the program. Of these, 14 have been discharged to community services. Five of the 14 have moved into transitional housing, nine have moved into supervised group settings such as family care homes or group homes. Five of the current Wright program residents are unlikely to be ready for discharge in the immediate future and will be transferred to other units of the hospital. Discharge planning is proceeding for the remaining eight residents. In nearly every case, either area program staff visited the resident in the Wright program, or hospital staff transported the resident to the receiving area program and providers in order to build rapport before discharge. Since the majority of Wright program residents will reside in Wake County, Wake Human Services Department staff and Dix hospital staff are meeting weekly to ensure that discharge plans are progressing appropriately.

*“There is a need for special transitional services to support those people who will be leaving the institutions and moving into the community.”*  
*State Plan feedback*

The Division is closely monitoring the discharge process and must approve all discharges from the program. All people discharged from the hospitals as part of the State Plan downsizing effort will be carefully monitored and tracked to ensure that their needs are met in the community settings they enter. Monitoring will include submission of a monthly service tracking form for each client, monthly review of community stability outcome measures, and monthly on-site visits by Division staff to meet with clients and/or review the progress of each individual discharged from the program.

### **Proposal for consolidated hospital**

The physical condition of the four state psychiatric hospitals is a constantly increasing drain on scarce system resources. Some of the hospitals date from the mid-nineteenth century, during the rise of the institution era. Others were pressed into use as hospitals, but built for a different purpose. All of them have been cobbled together at different times over the years in response to different needs; none of them is designed for efficient staffing; all of them are aging and in need of replacement or major renovation.

As part of the plan to reduce the total number of state psychiatric beds and find a long-term solution to the staggering costs of maintaining old facilities, Secretary Hooker-Odom has proposed a plan to consolidate two of the four state hospitals and build a single new facility in their place. John Umstead Hospital, serving 15 counties and seven area programs in the north central region of the state and Dorothea Dix Hospital, serving 16 counties and eight area programs in the south central region, would be closed. The new state-of-the-art hospital would serve a combined central region, consisting of 26 counties and 13 current area programs, with a combined population of 3,232,098 (July 2001 data). In this plan, two area programs are proposed to realign with the eastern region to more evenly balance the scope of geographic areas covered by the hospitals. Several possible sites in the proposed new central region are under consideration for the new

facility. The proposed design would closely resemble the design previously developed for a new Dorothea Dix Hospital.

### **Renovation and expansion of alcohol and drug abuse treatment centers (ADATCs)**

Plans are underway to expand the capacity of the ADATCs to provide acute crisis/detoxification services, thereby diverting people with substance abuse from admission to state psychiatric hospitals. These plans include design, development and renovations at Julian F. Keith ADATC, Black Mountain, an 80-bed residential treatment facility serving residents of western North Carolina; Walter B. Jones ADATC, Greenville, a 76-bed, short-term residential treatment center serving 33 counties in the eastern region and five counties in the south central region; and Butner ADATC, at Butner, a 60-bed acute and rehabilitation center serving sixteen counties of the north central region and ten counties of the south central region. The state has selected and contracted with architectural design firms, and the work has begun. Funding for these projects was obtained through the Mental Health Trust Fund.

### **Nursing beds expansion**

Plans are underway to expand the intermediate and skilled nursing level beds in the western region. Black Mountain Center, Black Mountain, currently serves 73 residents. Expansion will provide increased bed capacity and a mission that more closely matches the mission of the NC Special Care Center, Wilson.

### **Whitaker School closure**

Whitaker School is a residential treatment center located on the grounds of John Umstead Hospital, Butner, for 38 youth, ages 12-17. The condition of the present facility is such that the program cannot continue to operate in its present location. Additionally, the state wants to expand the program's re-education model of treatment, one that has proven successful, to other areas of the state. With funding from the Mental Health Trust Fund, two new centers are being developed to serve 18 adolescent boys and girls. The new units are scheduled to begin operation by December 2002, with full closure of the current Whitaker School facility by July 1, 2003.

### **Integrated payment and reporting system (IPRS)**

This initiative will eventually replace three existing systems of claims processing. It is designed to solve many technical problems of information and data collection and management. It will be built on the existing Medicaid Management Information System (MMIS) currently used to process Medicaid claims for the Division of Medical Assistance (DMA). IPRS has been piloted in two area programs and is scheduled to phase in statewide rollout from July 1, 2002, through June 30, 2003. Target population changes contained in this State Plan revision are currently being programmed into the IPRS system to be used for eligibility determination. Over the next year, the treatment,

services and supports comprising the benefit packages for people served by the reformed system will be added for implementation on July 1, 2003.

More detailed information on overall implementation activities and their scheduled timelines are presented in the part of this Plan describing the state strategic business plan. The work of implementation committees and workgroups and other information and updates about system reform developments is posted regularly on the Department web site.

State system reform is being implemented over a five-year period. Clearly, those years will consist of hard work; people in and outside of the mh/dd/sa system must work to overcome challenges and barriers, build and nurture new partnerships and learn new ways of working better and smarter. These things take time. However, the need for system reform has never been greater. The Division prepares quarterly reports for the Legislative Oversight Committee describing implementation progress. Each of these reports and other details about reform implementation are available on the Department web site at: <http://www.dhhs.state.nc.us/mhplan/>

A summary of the numbers of people in North Carolina who have disabilities and need services, supports and treatment is briefly described below.

## **SUMMARY OF NEEDS - ADULT MENTAL HEALTH**

### **Prevalence**

According to estimates by the federal Center for Mental Health Services, during a 12-month period, approximately 5.4 percent of the adult population has a serious mental illness. This means that in North Carolina, during a 12-month period, approximately 322,000 adults have a diagnosable mental, emotional or behavioral disorder that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Within this population, approximately 99,000 have severe and persistent mental illnesses (SPMI) that interfere substantially with their ability to manage the demands of daily living.

### **Population being served**

Current numbers of people being served/supported do not approach estimates of need projected for our state's population. In 1999-2000, area programs provided mental health treatment to 152,744 adults. Of that total, 24,764 were described as people with serious and persistent mental illness.

Of the total number of adults served by area programs, 88,844 were females, and 63,767 were males. Twenty-nine percent were African-American, 66 percent white and less than one percent of Hispanic origin. It should be noted that Hispanic individuals are underrepresented in the service

population. This group makes up over four percent of the adult population in NC, but less than one percent of the client population in the public mental health system. Given the projected rapid growth in the state's Hispanic population, this is an area in need of attention, as are other underrepresented minorities.

## SUMMARY OF NEEDS - CHILD MENTAL HEALTH

### Prevalence

North Carolina conservatively estimates 10 to 12 percent of the state's children experience serious emotional disturbance (SED). This is based on the prevalence rate cited in the June 1998 *Federal Register*. The NC Office of State Planning estimated in 1997 that there are 1,730,695 children in NC under age 18. The number of children in this age group with SED is between 173,069 and 207,683.

### Population being served

In 1999, area programs served 78,185 children and adolescents with, or at risk for, serious emotional disturbance. This represents a two percent increase over the previous year. Year 2000 data show 64,698 children served; however, this apparent decrease actually occurred due to a mid-year change in reporting systems. Approximately 2,941 children/youth served in 2001 have or are at risk for SED and at risk for out-of-home placements. These youth are predominantly male (76.6 percent male and 23.4 percent female). Among children served, 39 percent are African-American, 56.5 percent are White and 4.5 percent are described as "other."

The disparity between children served in any year and reliable estimates of need is enormous.

**TABLE 1: AGES OF CHILDREN SERVED BY AREA PROGRAMS**

<i>Age</i>	<i>Percent Female</i>	<i>Percent Male</i>	<i>Total Number</i>	<i>Total Percent</i>
Birth - 2	7.09	6.25	5,032	6.58
3 - 5	10.33	10.68	8,062	10.54
6 - 11	41.93	48.04	34,931	45.67
12 - 17	40.65	35.03	28,460	37.21

### Children with multiple diagnoses

Children with multiple diagnoses are included as a priority within target populations. In FY98, the total number of children was 76,485. Of them, 86 percent had two or more diagnoses, and 49 percent had three or more. Individuals with multiple disabilities typically require ongoing, integrated and comprehensive support for more than one major life activity in order to participate in community settings and enjoy the quality of life experienced by youngsters with fewer or no disabilities.

Multiple service systems (Department of Public Instruction, Departments of Social Services, Department of Juvenile Justice and Delinquency Prevention, etc.) serve these youth. Children and youth with multiple disabilities may exhibit a wide range of characteristics depending on the combination and severity of their disabilities and their age. Disabilities may include limited speech or communication, tendencies to forget skills, trouble generalizing skills and a need for support in a variety of life activities including leisure, vocational and community participation.

## **SUMMARY OF NEEDS - DEVELOPMENTAL DISABILITIES**

### **Prevalence**

The Division's developmental disabilities services section follows recommendations of the National Association of State Directors of Developmental Disabilities Services and uses the University of Minnesota's figure of 1.58 percent as a broad estimate of people in the total population with developmental disabilities. Of these, estimates are that .79 percent are adults and approximately three percent are children. This means that there are approximately 130,810 people in NC with developmental disabilities.

### **Population being served**

North Carolina's developmental disabilities system is at a crossroads in its evolution. It is a system that provides an extensive array of services and supports in its quest to meet the needs and preferences of the individuals it serves. The system provides services and supports to approximately 30,000 children and adults across the state. North Carolina's Home and Community-Based Waiver supports approximately 5,700 of these 30,000 (in NC, the HCBS waiver is known as CAP-MR/DD). In addition, developmental disability programs across the state keep an up-to-date waiting list of individuals in services who have requested new or additional services and people who are seeking services that are not available within existing resources.

Community services have expanded through an increase in the HCBS waiver (CAP-MR/DD) by 300 percent and increased state dollars appropriated for services. North Carolina rates among the top 10 states in the nation for the amount of funds used for family support. Over the past ten years, North Carolina has reduced the census of its public mental retardation centers through a planned system of downsizing. The state continues, however, to overly rely on public and private group care for people with developmental disabilities.



## SUMMARY OF NEEDS - SUBSTANCE ABUSE

### Prevalence

Data used in making projections of treatment needs are taken from North Carolina's first Center for Substance Abuse Treatment (CSAT) needs assessment studies conducted by the Research Triangle Institute. Estimates of people needing substance abuse services include:

- 784,000 people age 18 and above who needed substance abuse services.
- 2,600 homeless.
- 2,700 psychiatric patients.
- 9,700 imprisoned believed to be in need of substance abuse services.
- 47,555 public high school students.
- 4,917 school dropouts.
- 666 private school students.

### Population being served

North Carolina's public substance abuse service system is hospital and community-based, providing education, prevention, early intervention and treatment services to the state's residents. In fiscal year 2000, the public system served more than 88,000 adults and children throughout North Carolina's 100 counties. However, this figure represents less than one percent of the identified need. Substance abuse treatment and services account for only six percent of the overall funding for mh/dd/sa services, but the broader costs of untreated substance abuse related problems such as lost days worked, arrests, injuries and illnesses, family violence and other serious problems, multiply the state's total investment in substance abuse issues many times over.

## ADDRESSING DISPARITIES IN THE MH/DD/SA SYSTEM

Minority and ethnic groups are disproportionately represented within the present system. For example, according to the recently released Client Statistical Profile for 2000-2001, African-Americans made up 33.8 percent of persons served, or 61.1 per 1,000, the highest rate relative to their respective statewide population of 21.6 percent. The Hispanic/Latino population represents 4.7 percent of residents statewide, but only 1.39 percent of active service recipients, or 11.5 per 1,000. There may be many reasons for variations in minority representation. These may include cultural and socioeconomic issues as well as concerns about stigma or negative attitudes toward people with disabilities.

- Strategies that local systems can use in addressing these disparities include:
- Publishing written materials in languages reflective of the local population.
- Collaborating with the Minority Health Advisory Council on addressing barriers to services in local systems.
- Developing cultural competency.
- Using bi-lingual services as a paid skill.

- Making special efforts to recruit and hire qualified workers from different ethnic/racial groups.

Part of the local planning process leading to local business plans should be a thorough examination of the socioeconomic and ethnic/racial composition of each region and creation of strategies for meeting these special needs. Issues related to access to services and disparities in consumer outcomes by race/ethnicity, gender, sexual orientation, age, disability, geographical location, income and education level will be tracked as part of the outcomes system and will be included in *report cards*, published reports on outcomes. The *Client Statistical Profile for 2000-2001* is available for review on the Department web site at <http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm#Annual>

## Chapter 3: Designing a New Public System

### Who Will be Served and How Will They Gain Access

Since the release of *State Plan 2001: Blueprint for Change*, the Division has received many questions about core functions, access to services and target populations. These questions center around core functions as services available to all who need them; core functions versus a minimum, basic benefit package for target populations, often thought of as a set of core services; access to services and a standardized process to access them; and the differences in target populations among disability areas. This chapter provides more detail and attempts to clarify issues that have caused confusion.

### CORE FUNCTIONS

The reform statute requires that, within available resources, each local service system must assure that core functions are widely available. There are two types of core functions. One is the direct, individual-specific functions or services of screening, assessment and emergency triage. The other consists of the indirect functions or activities of prevention, education and consultation that are intended to benefit the greater community.

The term core functions does not refer to a minimum, basic set of services for target populations (medication management, acute detoxification or case management, as examples). Core functions are best thought of as pathways to system access. As such, they are closely connected to the concept of uniform portal, a consistent process for gaining access to system services and supports through any of many doors. The range of services to be provided for individuals in target populations referred to as benefit packages, is covered in Chapter 4 of this revision under array of services for target populations.

**Screening** is a brief standardized appraisal of an individual who is not currently being served within the system in order to determine the nature of the individual's problem and need for services and supports. This includes early periodic screening, diagnosis and treatment (EPSDT) and other federally mandated screening. Both financial and clinical information is gathered to determine next steps. The screening process is not an evaluation or assessment. Rather, it is a brief, structured interview conducted either face-to-face or by telephone to determine whether or not the individual should be referred for further services and, if so, to where.

**Assessment** is a follow-up next step if screening indicates that assessment is needed. It could include an evaluation of the nature and extent of the individual's problem or disability through a

systematic appraisal of the person's mental, psychological, physical, behavioral, functional, social, economic and intellectual resources. Its purposes are diagnosis, determination of the person's disability level, eligibility to be included in a targeted population and an evaluation of the situation's urgency and intensity of need.

**Referral** means offering information about available qualified providers, generic resources and community capacity to best meet the needs of the individual. This information will also be used by local community systems to help determine gaps in service and network development.

**Emergency triage and services** include a range of functions including crisis response activities such as 24-hour crisis hotline and urgent or emergent clinic/practitioner visits, to be available both to people who initially enter the system in crisis and to those in target populations who are already receiving system services. Also included are other crisis stabilization interventions such as family/caregiver respite, crisis shelters, detoxification services or emergency psychiatric hospitalization. These functions may not be located in every county; however, the services will be available for the public.

**Care coordination** as a core function means referring people not meeting criteria for public system eligibility but needing services, to appropriate community resources such as faith-based agencies, community organizations and 12-step self-help groups. It also refers to coordination of care for people, who may or may not be in target populations, who are being discharged from emergency or inpatient programs.

**Service coordination** is a separate and distinct administrative function. It involves ensuring that service elements throughout the region are seamlessly integrated, consistent in management policies and practices and consumer and family friendly. This is not the same as care management (a component of utilization management in managed care) or case management (a care-coordinating activity for specific individuals who are receiving treatment, services or supports within the system).

**Consultation** is provided to agencies, groups or organizations and to individual practitioners to promote planning and developing mh/dd/sa services. The local business plan will outline how the local service system will provide this service to the community.

**Education** is designed to inform and teach various groups including persons being served, families, schools, businesses, churches, industries, civic and other community groups about the nature of mh/dd/sa and services and supports in the state and community. The local business plan will outline how education will be provided.

**Universal prevention** is designed to inform and teach the population at large about insights and skills related to healthy living. The local business plan will outline how prevention will be provided.

## UNIFORM PORTAL

*Uniform portal* is a term used to describe a set of standardized processes and procedures that ensures that people throughout the state enter and leave publicly funded services in the same way. The pathways to access (the core functions of screening, referral, assessment and emergency management) provide the framework for uniform portal activities. These pathways to access, coupled with procedures for system discharge, essentially define uniform portal. There will be many access points, but standards must be consistent.

Access points may include:

- Any public agency in the county (such as social services, vocational rehabilitation, schools, public health).
- A statewide referral service.
- Qualified service providers in the local network.
- Local management entity.

A uniform access system:

- Ensures availability of information about services.
- Facilitates access to available, timely and appropriate treatment or services.
- Provides standardized, consistently implemented, statewide procedures that comply with best practices and are understandable to consumers.
- Provides mechanisms for receiving and responding to feedback from people with disabilities, family members and other stakeholders.
- Provides consistent and coherent information.

Elements of uniform portal activities such as screening and eligibility determination instruments, documentation and reporting methods, referral process development, basic and extensive assessment procedures and others are under development by an implementation workgroup. Details on implementation activities can be found in the state strategic business plan described elsewhere in this State Plan revision.

## STATEWIDE SYSTEM CONTRACTOR

A single, statewide contract will provide information and referral and a statewide crisis hotline and utilization management for certain high cost services. The contractor will support each LME by taking calls 24-hours-per day, seven-days-per-week, through a single, statewide toll-free telephone system. This will include patching crisis calls through directly to the LME or to the emergency/crisis

system within the region. The contractor will screen and refer people seeking help to system access points available in their local area and will provide LMEs with daily status reports of calls from specific areas. LMEs will be expected to assist the contractor in developing and maintaining a database of regional resources for referral.

The contractor will also provide utilization management (UM) for high cost services such as acute hospitalization, long-term facility placement, out-of-state placements or person-centered plans exceeding a fixed funding level. The contractor will have demonstrated competency at providing

services to people with substance abuse, developmental disabilities and mental illness. The contractor will be reimbursed on a cost-plus basis and will have no financial incentive for denying care. The LME will provide all other utilization management. Utilization criteria will be established by the state, and the state will work with the contract agency and LME to promote statewide efficiency and consistency while recognizing the need for LMEs to have sufficient flexibility in how they structure the local service array to meet specialized needs. One or more LMEs who are in the first phase-in group may be selected to model or pilot full utilization management at the local level. Depending on the outcome of this demonstration, additional LMEs may be authorized to fully manage utilization in the second and succeeding three-year local business planning periods.

*“Uniform portal needs to be more clearly defined. Without clear standards and definitions we are fearful that uniform will be anything but uniform.”*  
State Plan feedback

## SYSTEM ACCESS

Access to the service system will be available 24-hours-a-day, seven-days-a-week (24/7) through crisis phone lines and, if needed, face-to-face contacts. People seeking services for the first time will receive a brief screening using a single standardized process. Screening will determine the seriousness of a person’s needs and whether the person should be referred for an assessment. Everyone should have access to a reasonable and responsible level of care.

The individual will be referred if he/she is eligible or could be eligible for services. If the ideal service is not available, interim services may be provided. Very brief services may be provided if the assessment determines that the individual is not in a target population for priority services, but needs services. However, this may not interfere with financing or cause delay in service delivery to target populations. Referral should be made to community-based agencies, self help groups, faith-based initiatives or other such resources developed by the LME as part of the local service network.

Emergency services include the 24/7-phone line provided by the centralized utilization management contractor, walk-in emergency/urgent care, crisis shelter/respite beds and psychiatric inpatient beds. Limited care coordination will be provided to non-targeted individuals discharged from an emergency service in order to assure appropriate follow-up by other community services such as an independently enrolled qualified provider, a community-based agency or a self-help group.

Discharged individuals who are part of target populations will be referred to the appropriate system of care.

## TARGET POPULATIONS

Providing services to individuals with the most severe disabilities is the primary focus of the re-designed system. Appropriate criteria to identify individuals with various disabilities and the greatest needs include diagnostic and functional elements as well as circumstances unique to each individual. Availability and access to appropriate services that meet the needs of each person served shall also be considered. The urgency and intensity of needs chart (in appendix) will be applied throughout the system to establish a structured process for prioritizing services and/or managing waiting lists. Clinical diagnoses are made according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R). Classification for billing purposes is made according to the International Classification of Diseases (ICD-9).

*"We need much more clarity on who will be eligible for services and how eligibility determinations will be made."*  
State Plan feedback

Minorities are disproportionately represented in the service system. Special efforts need to be made to serve minorities appropriately. Definitions of target populations have been adjusted in this revision based on questions and feedback from system stakeholders.

## ADULT MENTAL HEALTH SERVICES TARGET POPULATIONS

*Mental illnesses are disorders characterized by disturbances in a person's thoughts, emotions or behavior. The term mental illness can refer to a wide variety of disorders, ranging from those that cause mild distress to those that severely impair a person's ability to function.*

The resources of the adult public mental health delivery system are targeted to adults with severe and serious mental illness. Within the resources available, the system will provide, at a minimum, a base level of service to all persons in the target population who seek services or who can be engaged through outreach activities. Additionally, as recommended in a study by the Public Consulting Group<sup>1</sup>, priorities are established within target populations to guide development and the provision of specialty services and programs to people with the most significant disabilities. Recent advances in treatment for individuals with serious mental illness (SMI) and severe and persistent mental illness (SPMI) make it possible for individuals with these conditions to live far more satisfying lives than ever before. The system for adults with SPMI and SMI adopts a rehabilitation and recovery model focusing on providing or assisting individuals to obtain and maintain the skills they need to live as normally as possible in communities of their choice.

## Adult mental health target populations for community services

### ***Persons with severe and persistent mental illness***

These are people who are 18 years or older and, resulting from a mental illness, exhibit functioning that is so impaired it interferes substantially with their capacity to remain in their communities.

Their mental disability limits their ability to function in activities of daily living such as interpersonal relations, homemaking, self-care, employment and recreation. The following diagnoses are included: schizophrenia, schizoaffective and schizophreniform disorders, bipolar disorder, major depressive disorder and psychotic disorder not otherwise specified. Functional status is assessed using the Global Assessment of Functioning<sup>2</sup> (GAF).

People in this target population include:

- People newly admitted for services who meet the diagnostic criteria and who have an initial GAF score of 40 or lower.  
OR
- Current clients, as of July 1, 2002, who meet the diagnostic criteria, but did not have a GAF assessment when they were admitted, as a result of effective treatment do not currently meet criteria and without ongoing treatment and supports would likely experience greater disability and again meet level of functioning criteria.  
OR
- New clients who meet the diagnostic criteria but do not currently meet the GAF criteria and no previous GAF score is available, may be presumed eligible based on having a history of two or more hospitalizations, two or more arrests or homelessness.

### ***Persons with serious mental illness***

These are people 18 years or older who have a mental, behavioral, or emotional disorder that can be diagnosed and substantially interferes with one or more major life activities. These include delusional disorders, shared psychotic disorders, dissociative disorders, factitious disorders, obsessive-compulsive disorders, phobias, dysthymic disorder, borderline personality disorder, pedophilia, exhibitionism, anorexia, bulimia, post traumatic stress disorder, depressive disorder not otherwise specified, impulse control disorder and intermittent explosive disorder. Functional status is assessed using the GAF.

People in this target population include:

- People newly admitted for services who meet the diagnostic criteria and who have an initial GAF score of 50 or lower.  
OR
- Current clients, as of July 1, 2002, who meet the diagnostic criteria, but did not have a GAF assessment when they were admitted, as a result of effective treatment do not currently meet criteria and without ongoing treatment and supports would likely experience greater disability and again meet level of functioning criteria.  
OR
- New clients who meet the diagnostic criteria but do not currently meet the GAF criteria and no previous GAF score is available, may be presumed eligible based on having a history of two or more hospitalizations, two or more arrests or homelessness.



## Priority populations within target populations

- Persons with multiple diagnoses: *Persons 18 or older with a severe and persistent mental illness and a diagnosis of substance abuse and/or mental retardation or serious health problem including HIV disease.*
- Persons who are homeless and mentally ill: *Persons 18 or older with a serious long-term mental illness or a serious long term mental illness and substance abuse diagnosis who lack fixed, regular and adequate nighttime residence.*
- Mentally ill adults in the criminal justice system: *Persons 18 or older with serious mental illness who are released from the Division of Prisons, or are in local jails or on probation.*
- Elderly persons: *Persons age 65 and over with a serious mental illness, including dementia.*
- Deaf mentally ill persons: *Persons 18 or older with a mental, behavioral or emotional disorder that can be diagnosed who need specialized services provided by staff who have American Sign Language skills and knowledge of deaf culture.*
- Minorities: *Adults with severe and persistent mental illness who are disproportionately represented in the system.*

## Adult mental health target populations for state hospitals

In the next five years, state hospitals should revise their complement of beds and services to focus on their mission of providing psychiatric inpatient care to individuals with severe mental illness who cannot be appropriately treated in their local communities. Efforts already underway to prevent unnecessary institutionalization by directing people to local service providers whenever possible will continue.

### **Primary populations to be served among state hospitals**

- *Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression, and some personality disorders, requiring brief acute inpatient treatment of a few days to stabilize and return to their communities.*
- *Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression, and some personality disorders, requiring long-term inpatient rehabilitative treatment of approximately three to six months, to prevent or correct a rapid relapse and readmission cycle, or who remain dangerous to self or others.*
- *Children with severe emotional disorders requiring acute inpatient treatment to stabilize and return to a less restrictive environment.*
- *Older adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders requiring acute inpatient treatment to stabilize and return to their communities.*
- *Adults with psychiatric illness and substance abuse disorders, or serious illness such as HIV requiring acute and/or longer-term inpatient treatment to stabilize and prevent rapid relapse and readmission.*

### **Specialty populations to be served**

- Forensic patients, including those found incapable of proceeding with court trials (House Bill 95), not guilty by reason of insanity and other detainees.
- Patients taking part in a research protocol.
- Deaf consumers requiring acute or long-term inpatient psychiatric services.

## Adult mental health target populations the NC Special Care Center

The NC Special Care Center's mission is to provide intermediate and skilled nursing care for individuals referred from state hospitals and for people who can't be served in their communities because of insufficient bed-space and insufficient psychiatric services of the intensity needed.

### ***Primary populations to be served***

- Consumers with severe mental illness requiring ICF level of nursing care (intermediate care facility).
- Consumers with severe mental illness requiring SNF level of nursing level care (skilled nursing facility).

### ***Specialty population to be served***

*Consumers with mid-stage Alzheimer's disease requiring nursing care.*

*"Children with a serious emotional disturbance are persons from birth up to age 18, who are currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder meeting diagnostic criteria specified within the DSM-IVR, and that resulted in functional impairment that interferes with or limits the child's role or functioning in family, school or community activities."*

*The Center for Mental Health Services*

## CHILD MENTAL HEALTH SERVICES TARGET POPULATIONS

### **Target Population 1 (Severe)**

#### **Children with Serious Emotional Disturbance (SED).**

- Children under 18 years of age with atypical development (up to age 5) or serious emotional disturbance (SED) defined by the presence of a mental, behavioral or emotional disturbance that can be diagnosed. These children will have priority if they are also identified as sexually aggressive and/or deaf and/or if they have dual or multiple diagnoses.  
AND
- Functional impairment that seriously interferes with or limits the child's role or functioning in family, school, or community activities as indicated by:
  - A Child and Adolescent Functional Assessment Scale (CAFAS) score of at least 90, or the total CAFAS score is greater than 60, but it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.OR

- In need of services from more than one child-serving agency (e.g., MH/DD/SAS, Department of Social Services, Department of Public Instruction/Schools (other than regular education), Department of Juvenile Justice and Delinquency Prevention, public Health, health care, other community organizations/providers) and informal supports and services.

AND

- Placed out of the home or at risk of out-of-home placement, as evidenced by any of the following:
    - Using or having used acute crisis intervention services in the past year or intensive wraparound services in order to maintain community placement.
    - Having had three or more state or private hospitalizations in the past year or at least one hospitalization of sixty continuous days.
    - DSS has substantiated abuse, neglect or dependency in the past year.
    - Been expelled from two or more daycare or pre-kindergarten programs in the past year.
    - Within the past year, convicted of a felony or two or more serious misdemeanors in juvenile/adult court or currently placed in a youth advocacy program (training school), prison juvenile detention center or jail.
- Situation worsened by special need (such as chronic health conditions such as diabetes, deafness, sexually aggressive).

**NOTE:** Must meet **Level D criteria** in the Child Level of Care document for specific services.

### **Target population 2 (Moderate)**

#### **Children with SED (serious emotional disturbance)**

- Children under 18 years of age with atypical development (up to age 5) or serious emotional disturbance (SED).
- AND
- Have functional impairments that significantly interfere with or limits their role or functioning in family, school or community activities.
  - Children with moderate functional difficulties in home, childcare, school or community activities that lead to a CAFAS score of at least 60, or a total CAFAS score that is greater than 30, but it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

**NOTE:** Must meet **Level C criteria** in the Child Level of Care document for specific services.

### **Target Population 3 (Deaf)**

Children who are deaf and have SED (serious emotional disturbance) and a diagnosis of mental illness AND need specialized services provided by staff having American Sign Language skills and knowledge of deaf culture. These children must have a psychiatric disorder; however there is no specific requirement regarding function as measured by a CAFAS score.

### **Target Population 4 (Homeless)**

Children who are homeless and have SED (serious emotional disturbance) and a diagnosis of mental illness AND who lack fixed, regular, adequate nighttime residence or have a primary nighttime residence that is a) a temporary shelter or b) temporary residence for individuals who would otherwise be institutionalized or c) a place that is not designed/used as regular sleeping accommo-

dations for human beings or are at imminent risk for homelessness. There is no specific requirement regarding function as measured by CAFAS score.

**Note:** *Assertive outreach can be provided to homeless children who have not yet been diagnosed.*

## DEVELOPMENTAL DISABILITIES SERVICES

Developmental disability *means a severe, chronic disability of a person that:*

- Is attributable to a mental or physical impairment or combination of mental and physical impairments.
  - Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22.
  - Is likely to continue indefinitely.
  - Results in substantial functional limitation in three or more of the following areas of major life activity: self care, receptive and expressive language, capacity for independent living, learning, mobility, self direction and economic self-sufficiency.
- AND
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.
  - When applied to children from birth through four years of age may be evidenced as a developmental delay.

### Developmental disabilities target population for community services

In the late 1980's, North Carolina adopted the federal functional definition of developmental disability, which in essence, targeted the population to those most impacted by disability. While this definition presumes that mental illness is not the cause or origin of the primary disability, it is acknowledged that those individuals who meet this functional definition may experience a co-occurring mental illness.

Developmental disabilities services are provided throughout a broad and diverse population. The target population is created by the application of a functional rather than diagnostic definition and is applicable throughout the lifetime of most individuals who are eligible for services. Since people with developmental disabilities, uncomplicated by secondary conditions, do not have an illness that is amenable to medical treatment, services and supports for these individuals focus almost entirely on interventions that strengthen the individual's ability to manage community living conditions and maintain or build a reliable personal support system.

All people currently in services meet the target population criteria, but they may be receiving services/supports inappropriate to their level of need. The requirement in the new system for re-

assessment of individuals already receiving services is to correct any mismatches that currently exist.

## SUBSTANCE ABUSE SERVICES

### Substance abuse target population

The most significant opportunity to reduce the burden of substance abuse on public programs is through targeted and effective prevention programs. If children can be kept from smoking cigarettes, using illicit drugs and abusing alcohol until they are 21, the risk for future addiction is substantially reduced. Treatment is also a cost-effective intervention, as it reduces the costs to state programs in the short term and avoids future costs. North Carolina will make targeted interventions for selected populations that hold promise for high return. As savings and new resources become available to expand service system capacity, additional populations will be added to the list of those targeted for services.

### Target populations for substance abuse services (eligibility criteria)

All individuals will be assessed for service eligibility on the basis of the American Society of Addiction Medicine (ASAM) patient placement criteria for the treatment of substance-related disorders (PPC).

### Injecting drug users, those with communicable disease and/or those enrolled in opioid treatment programs:

- Adults currently (within 30 days) injecting a drug under the skin, into the muscle, or into a vein for non-medically sanctioned use and meet criteria for a substance-related disorder.  
OR
- Adults infected with HIV, tuberculosis, or hepatitis B, C, or D and meeting criteria for a substance-related disorder.  
OR
- Adults who meet criteria for dependence to an opioid drug, are addicted at least one year before admission, are 18 years of age or older and are enrolled in an opioid treatment program.

### Substance abusing women with children

- Women who meet criteria for a substance-related disorder (primary diagnosis for child only).  
AND
- Adults who are currently pregnant or who have dependent children under 18 years of age or who are seeking custody of a child under 18 years of age.  
OR
- Adolescents women who are currently pregnant or who have dependent children under 18 years of age.

***DSS-involved parents who are substance abusers***

- DSS involved adult parents who are substance abusers include those who have legal custody of a child or children under 18 years of age and who meet criteria for a substance-related disorder.  
AND
- Who are under active investigation or supervision by Child Protective Services for suspected or substantiated child abuse or neglect.  
OR
- Who are authorized by DSS to receive Work First assistance and/or services.

***High management adult substance abusers***

- Adults who meet criteria for a substance-related disorder.  
AND
- Are currently involuntarily committed to substance abuse treatment (legally determined to be dangerous to self or others and may have co-occurring mental illness).  
OR
- Have a substance use pattern of recurring episodes of habitual use with multiple documented unsuccessful treatment episodes that may include assisted detoxification, and who are advanced in their disease and who have no social or environmental supports and who have few coping skills and who may be highly resistive to treatment and who may have co-occurring disorders (excluding the severe and persistent mental illness (SPMI) and the serious mental illness (SMI) populations) and who may have moderate biomedical conditions.

***Substance abusing individuals who are involved in the criminal justice system***

- Adult or adolescent criminal justice clients who meet criteria for a substance-related disorder (primary diagnosis for child only).  
AND
- Whose services are authorized by a TASC Program Care Manager.  
AND
- Who voluntarily consent to participate in substance abuse treatment services.
- Primary substance abusing criminal justice populations include:
- Intermediate punishment offenders.
- Department of Correction releases (parole or post-release) who have completed a treatment program while in custody.
- Community punishment violators at-risk for revocation.

***DWI offenders***

- Adults or adolescents who are convicted of driving while impaired, commercial DWI or driving under 21 years of age after consuming alcohol or other drugs.  
AND
- Who have completed a DWI assessment and have been identified with a substance abuse handicap based on criteria for a substance-related disorder (primary diagnosis for child only).  
AND
- Who have paid the legislatively mandated fees for substance abuse assessment and treatment.  
AND

- Who have a family income of no more than the current federal income standard of 200 percent of poverty.

### ***Deaf and hard of hearing***

*Adult clients who are 18 years or older and who have a substance-related disorder and who have been assessed as having special communication needs because of deafness or hearing loss.*

### ***Children and adolescents with primary substance-related disorders***

Children and adolescents with a primary substance-related disorder.

### ***Child substance abuse selective prevention***

*A child or adolescent under 18 years of age determined to be at elevated risk for substance abuse and who:*

- Is currently experiencing documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school  
OR
- Has documented negative involvement with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort.  
OR
- Has one or both parents, legal guardians, or caregivers who have one or more documented child abuse or neglect reports, investigations or substantiated incidents involving DSS.  
OR
- Has one or both parents, legal guardians, or caregivers who have a documented substance-related disorder.

Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet the criteria for other conditions that may be a focus of clinical attention. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

### ***Child substance abuse indicated prevention***

Child or adolescent under 18 years of age who is using alcohol or other drugs at a pre-clinical level (child or adolescent does not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria and who:

- Is currently experiencing documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion, or dropping out of school.  
OR
- Has documented negative involvement with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort.  
OR
- Has one or both parents, legal guardians, or caregivers who have one or more documented child abuse or neglect reports, investigations, or substantiated investigations involving DSS.  
OR

- Has one or both parents, legal guardians, or caregivers who have a documented substance-related disorder.

Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

### ***Priorities within target populations***

- Adult and child pregnant injecting drug users.
- Adult and child pregnant substance abusers.
- Adult and child injecting drug users.
- Children and adolescents who are involved in the juvenile justice or the social services system, who are having problems in school or whose parent(s) are receiving substance abuse treatment services.
- Adult and child deaf persons who need special services provided by staff who have American Sign Language skills and knowledge of the deaf culture.
- Adult and child clients who have co-occurring physical disabilities.
- Adult and child homeless clients
- All others.

### ***Persons with substance abuse and mental illness***

LMEs will be required to ensure that services are provided to individuals who experience substance abuse problems along with co-existing physical or cognitive disability. All services to adults with multiple disorders should address both the mental health and substance abuse needs in a coordinated, integrated manner. The primary responsibility shall be assigned as described here:

- Adult Mental Health Services shall have primary responsibility for mentally ill individuals who also abuse substances. *This includes adults who have a diagnosis of severe and persistent mental illness, including schizophrenia, bipolar disorder, schizoaffective disorder, recurrent major depression, or borderline personality disorder and in addition, have a substance abuse problem.*
- Substance Abuse Services shall have primary responsibility for consumers with substance abuse/dependence disorders who also have a mental illness. *This includes adults who carry a diagnosis of substance abuse/dependence and in addition and have a mental health diagnosis other than those listed above, which could include other Axis II disorders.*

### ***Co-occurring disorders:***

Individuals who meet the criteria for a target population often have more than one disability. People with severe and persistent mental illness, (or SED in a young person), may also have a developmental disability or mental retardation and/or a substance abuse problem. Such a pattern can occur among all disabilities in any combination, although the co-occurring disorder(s), taken alone, may not reach the level of a target population in the second category(s).

Generally, systems have done a poor job of recognizing and responding to these situations. Many organizations tend to focus their attention on specialized responses to a single disability – adult mental health, child mental health, developmental disability or substance abuse and fail to recog-



nize and address accompanying problems. Sometimes public funding mechanisms and budgetary rules get in the way of appropriately addressing all of an individual's needs.

The State Plan for system reform adopts a cross-disability approach that requires response to all of the conditions that affect successful community living. Clinicians must be able to assess for co-occurring disorders and treatment, and services and supports need to be integrated across all disabilities.

<sup>1</sup> This study, commissioned by the NC Legislature, included detailed recommendations designed to make the overall mental health delivery system more responsive to the needs of North Carolinians..

<sup>2</sup> An assessment tool measuring the overall level at which an individual functions including social, occupational, academic, and other areas of personal performance and that may be expressed as a numerical score." (<http://www.behavenet.com/capsules/disorders/GAF.htm>)

*"Substance abuse and dependence is a complex disorder, with associated biological, psychological, and social causes and effects. Historically, this disorder has been treated as a social problem while the psychological and biological aspects have been largely ignored. However, the deterioration of functioning within each of these aspects requires that treatment and interventions address the entire biopsychosocial continuum. Substance abuse and dependence is progressive, chronic and relapsing. Although many of the symptoms and associated illnesses require that an individual receive specialized acute care, systems should also be prepared to treat the chronic elements of the illness. People with alcohol and drug abuse disorders are defined as individuals who meet DSM IVR diagnostic criteria for receiving intervention or treatment whether the nature of their presenting problem is biological, social, or psychological."*  
CSAT, November, 2000



## CHAPTER 4: RESPONDING TO THE NEEDS OF PEOPLE WITH DISABILITIES

Whether considering the needs of a single person or building a system to meet the needs of many people, the fundamental interest is in *how* we support people with disabilities so that they may best achieve real life outcomes—lives that are not fundamentally different from what we ourselves cherish as full citizens. The focus moves away from facility-based care to communities where real people live real lives. The task becomes one of developing community capacity to genuinely welcome citizens with disabilities.

### COMMUNITY CAPACITY

The concept of *welcoming* refers to the community's ability to respect and value people with disabilities. This includes the availability of ordinary resources such as housing, transportation, employment and education as well as opportunities for developing friendships and social interactions, advancing spiritual desires and exercising civic interests. Additionally, the concept of community capacity involves recognizing individual and unique desires and needs of people with disabilities and developing the additional specialty responses of care, treatment, service, accommodation and support needed for successful living in a community environment. Specialty responses include methods that respond to routine desires and needs as well as acute or crisis situations. They are often referred to as *models of practice*.

*"It seems to me a major roadblock in providing a consistent home/ community based system of care for children and/or their families is transportation (more specifically, the lack thereof)."*  
State Plan feedback

Over recent decades, but particularly in the last ten years, there have been advances defined as *best practices* or *emerging best practices*. These are models of practice that have demonstrated the ability, when applied correctly, to promote real and valued outcomes for people with disabilities. These outcomes relate to issues such as improved general health, protection and prevention of adverse events like homelessness or jail imprisonment, increased employment, opportunities to develop satisfying relationships and greater personal satisfaction. Additionally, advances in medicine allow people with treatable conditions such as mental illness or addictive disorders far greater freedom from troubling symptoms that interfere with meaningful community life. Taken together, community (natural) and specialty developments merge as the full array of accommodation, care, treatment, service and support that constitutes community capacity.

The *best* and *emerging best* practice models adopted in the State Plan are based on philosophical and theoretical frameworks that have varying usefulness among all disability groups. Some may be

implemented immediately while others will need to occur gradually. These are briefly defined below.

### Consumer driven

This concept is often referred to as *consumerism* or *consumer empowerment*. The intention is to promote systems of support and/or services that are controlled by people with disabilities. Some models of practice may involve shared control, such as that in a psychosocial clubhouse, while others, such as drop-in centers or consumer cooperatives, are controlled solely by people with disabilities. Some models like Alcoholics Anonymous, Schizophrenics Anonymous and peer relationship and support building are defined solely as support oriented.

Opportunities for people with disabilities to take active participatory or leadership roles in public and private systems is a hallmark of consumer driven systems. This includes assuring that individuals are supported and accommodated, provided skill and knowledge acquisition opportunities related to their roles and responsibilities and compensated and/or recognized for their efforts.

### Consumer friendly

Customer friendly systems pay attention to issues that affect actual consumer experiences with systems of service. These issues include concerns with ease of access, staff attitudes, accommodations made for physical and other disabilities and communication throughout all aspects of all systems—from the point of entry to the point of exit. This practice requires that management and provider systems alike operate in a manner that promotes a user friendly, responsive customer service orientation in all aspects of support, services, care and treatment.

*“By our silence, we  
let others define us.”  
Susan Rook,  
recovering alcoholic  
& addict advocate*

### Self-determination

*Self-determination* incorporates a set of concepts and values underscorinf a belief that people who require support as a result of a disability should be able to define what they need in terms of the life they seek, have access to meaningful choices and have control over their lives. Within the state’s public mh/dd/sa system, self-determination involves assuring that services and supports for people are not only person-centered, but person-defined and person-controlled. Self-determination is based in five principles:

- **Freedom** to live a meaningful life in the community.
- **Authority** over how a limited amount of dollars are spent for needed for service/supports.
- **Supports** to organize and obtain resources in ways that are life enhancing and meaningful.
- **Responsibility** for the wise use of public dollars.
- **Confirmation** of the important leadership that self advocates must hold in a newly designed system.

To move toward a life that is self-determined, families and individuals with disabilities need information, assistance and education to assist them in becoming skilled at making informed choices and in recognizing and choosing the services and supports they need. The system must be prepared to provide competent assistance when there is a need for specialized services, supports and treatments. Self-determination principles do not minimize or make marginal the clinical or treatment needs of individuals with disabilities. There is an expectation that people will be supported in and will be responsible for seeking out needed services in order to benefit from a life a full community citizenship.

### Person-centered planning

Person-centered planning (PCP) is an on-going process fundamental to consumer driven systems, in which the individual with the disability assumes an informed and in-command role for life planning. For a minor child, the concept extends to the family group. For *any* person, the process includes other people who the individual invites to participate. Planning is focused on development of real life outcomes and a corresponding plan for achieving those outcomes. The process includes ensuring that individuals are fully informed and afforded opportunities to be supported in exploring new life experiences. PCP also includes developing responses for health and safety concerns, acute or chronic treatment needs, crisis contingency planning, services or programs that may be useful and desirable and any special supports that may be needed to increase opportunities for success.

*“Consumers & families who participate in quality management & service monitoring activities should have avenues to report their findings to someone at the state level as well as to the LMEs.”*  
State Plan feedback

Person-centered planning **is not** *carte blanche*; that is, the process does not give full authority to do anything desired. Neither does it dump responsibilities on natural supporters or systems. *All* people express desires and dreams and work to pursue these life aspirations through the expansion of resources (particularly personal and natural) but also within the constraints of available resources. The PCP process acknowledges that services, treatment and care needs operate within practice standards and are not unlike what occurs in natural systems. The process accepts use of publicly sponsored specialty resources as the *financing of last resort* relative to an individual’s plan.

Person-centered planning results in an Individual Support Plan (ISP). An ISP translates the learning acquired from the PCP into a set of real life outcomes and a corresponding set of methods, responsibilities and resources necessary to pursue and ultimately achieve those outcomes. Support plans also address crisis contingencies and health and safety issues. Specialty supports and services, including care and treatment that may be needed, are part of the ISP whether used occasionally or on a frequent, ongoing basis.

## Cultural competence

Culturally competent systems acknowledge and respect the scope and breadth of diversity that characterizes contemporary society. People who identify themselves with a particular ethnic, cultural or religious grouping have established cultural norms or practices such as customs, language, symbolism, rituals and social or behavioral expectations. Cultural competence means that these cultural norms are recognized, accommodated and respected. Culturally competent systems, both management and provider, acknowledge and demonstrate appreciation and respect for human diversity.

## Recovery

*Recovery* is a philosophical framework that recognizes and accepts chronic disability as part of the person's life-long experience. The concept of recovery has been traditionally associated with the alcohol and substance abuse recovery movement emphasizing self-help, mutual support and fellowship. Over the past several decades, recovery has emerged as a foundation on which best practice interventions for adults with serious mental illness are designed. For mental illness, the recovery approach can be compared somewhat to a person who undergoes a serious accident or illness and recovers from the acute event but retains some lingering residual effects or functional problems. A recovery-oriented model presumes that individuals can learn to effectively manage their symptoms, maximize their level of functioning and go on to attain a life of meaning, productivity and satisfaction. For both mental health and substance abuse, the recovery philosophy emphasis is on development of the individual's coping mechanisms and self-esteem primarily derived from learning, self help, peer support and pursuit of valued life roles.

*"Eighty-seven percent of people in the recovery community say it is very important for the American public to know the basic facts about addiction and recovery."*  
*The Alliance Project, 2000*

## Systems of support

This is a concept most often referred to as *system of care* in connection with supports and services for children and families. Although NC currently employs this practice for children, the concepts are generic throughout all ages and disabilities. System of care is intended to promote stability and healthy development of life domains within the context of a natural community environment. The individual and people representing key close relationships are at the inner core of the system of support. Peers and professionals build from that core. As applicable, systems of support extend outwards beyond the specialty system to include other public agents and community resources such as schools, public health, social services systems, faith-based organizations and advocates.

## ARRAY OF SERVICES FOR TARGET POPULATIONS

Service and support selections for an individual's support plan (ISP) may be drawn from any or all of an array of options using the models of practice adopted by the State Plan and developed by the local service systems. Some specialty resources may be shared within various geographic areas or developed in cooperation with other agencies, qualified providers or public services. A key element for approval of each local business plan will be the creativity, innovation, breadth and inclusiveness of its proposed service array for targeted populations, including those with co-occurring disorders and other special needs, including diversity.

As local communities plan their capacity development strategies, it is important to distinguish the differences between and among the terms that, collectively, describe the public specialty system.

**Supports** are non-fixed, fluid, individualized arrangements intended to promote a natural community life for people with disabilities. These may be human, technical and/or financial resources applied to help individuals acquire natural housing, supported living, employment (supported and competitive employment), education (supported education) and other assistance needed by the person to operate in the community.

**Services** are defined as programs that serve as natural community substitutes, such as residential programs or day programs, that are typically in fixed locations (physical plants) and not individualized but rather structured to respond to a group of people.

**Treatment** (and care) is defined as single or multiple integrated interventions provided within a scope of practice such as psychiatry, nursing, social work, occupational therapy and many others intended to respond to behavioral, health, psychiatric, habilitative and/or rehabilitative needs of an individual. Treatment may also be provided as part of a service array in a fixed program such as community psychiatric inpatient or detoxification programs.

People with disabilities also need advocacy and personal assistance to help them take full advantage of available resources or ones that can be constructed in response to identified desires and needs. This kind of advocacy goes by many terms often used interchangeably, such as care management, case management, service coordination and others. For purposes of consistency, the State Plan adopts these definitions:

- *Case Management* is an overarching function involving five dynamic and interrelated processes: assessment, planning, linking, coordinating and monitoring for individual consumers. There are several case management models of practice that reflect variation in the manner in which the five processes are carried out and in the corresponding required set of skills.

*We want a more efficient use of services and better-managed resources. We should look at outcome-based services.*  
*State Plan feedback*

- *Support Coordination* is a part of the case management function that involves facilitating person-centered planning in the event that an independent person, including a member of the individual's planning circle, or the individual is not facilitating the plan. Support coordination also refers to implementing and managing the ISP.
- *Assertive Community Treatment (ACT) and Home-based wrap-around (HB)* are sometimes referred to as *comprehensive case management* models. North Carolina defines these as *services* rather than *functions*. ACT is a self-contained community-based comprehensive service team, and HB *wrap-around* involves individuals who are able to perform the function of case management and also community-based therapeutic services. Both of these services include the functions of support coordination and clinical case management.
- *Care management* is an activity intended to assure that levels of care match the identified needs of the person-centered planning and assessment process and are cost effective. Care management is not an advocacy or personal assistance function.
- *Service coordination*, as used in the reform statute and the original version of the State Plan, is an administrative function designed to assure that all components of the local system operate in an integrated, consistent manner that is customer friendly. Service coordination is not an advocacy or personal assistance function.

The resources contained in an ISP are drawn from any or all of the array of services, supports, care and treatment as well as those that are individually crafted and completely unique to meet the special needs of the individual. The ISP should typically address the following areas.

### **Housing/residential**

Housing/residential services are ideally obtained in natural community housing initiatives designed to ensure that an individual lives with maximum independence in the least restrictive settings, such as independent single or shared living quarters in communities with or without on-site support. Other options include:

- Living with family or friends with adequate support/respite services.
- Small, home-like facilities in local communities close to families and friends, with the goal of moving to a less structured living arrangement when appropriate.

Residential placements also include any equipment and supplies needed to assist in successful, long-term housing stability. Admissions to state or private hospitals, mental retardation centers, state schools or any other institutional facility are not permanent or long-term residential options



and are meant to be placements of last resort. Admissions to facilities are considered negative events and poor outcomes. As such, facility admissions can be viewed largely as failures of the system to recognize and act to meet the changing needs of an individual's condition or circumstances.

## **Transportation**

A voucher system will be created to help individuals reach services. Vouchers can be used for public transportation or to pay neighbors to provide transportation. In areas where no public transportation exists, LMEs will design ways to assure access, including taking services or programs to people with disabilities in their communities on a regular basis. The LME may need to collaborate with local public or private agencies to pool resources and community facilities

*"...it would seem that transportation is the key to getting people to where they can access services."  
State Plan feedback*

## **Treatment, symptom management, therapies**

People who have psychiatric symptoms, substance abuse problems, developmental disabilities, co-occurring disorders, or other conditions amenable to medication management; physical, speech, or occupational therapy; or brief and intensive psychotherapy must have these services locally available. In urban areas, services can be offered in a broad variety of settings suitable to the needs of the individual. In rural areas, services may need to be taken to the area on a regular basis. Other interventions may include detoxification services, outpatient or inpatient substance abuse treatments with varying levels of intensity, therapeutic communities and services to people with co-occurring disorders.

## **Work, school, activity, leisure**

There are many services teaching living skills that make the most of the individual's ability to adapt to his/her environment, engage in meaningful work, and develop satisfying, lasting relationships. These include rehabilitation; before and after school activities; pre-vocational and vocational training; employment, health and wellness education; substance abuse prevention or treatment; employment transition services and others.

All such activities need to emphasize personal empowerment and offer constant opportunities to learn, develop and exercise increasing levels of self-determination, recovery and control. Program activities need to flow with the natural rhythms of daily life (i.e. work/study in the daytime, recreation and play after work and on weekends). Programs may not be composed of static, repetitive activities that do not teach, develop, empower or guide the individual toward a more effective and independent lifestyle.

**Wrap-around services**

Wrap-around services can include virtually any support or resource dictated by the unique needs of individuals and their families. Examples include family respite supports, family education and training, various peer supports and activities, personal support, live-in caregiver, day supports, Assertive Community Treatment teams, case management and support coordination. Also included are assertive outreach, interpreter services, case consultation and any other services/supports needed to enable individuals to live successfully in their communities.

**Crisis, emergency, including core emergency services**

These include a range of emergency management services including short term diversion beds, crisis stabilization, after hours services, detoxification, facility-based crisis services, crisis hotline, walk-in services and inpatient hospitalization. The emphasis in emergency services must be on planning (including advanced directives in the ISP), early intervention and stabilization, or other strategies for avoiding the need for intensive inpatient or acute residential services.

In addition to the more traditional set of crisis/emergency services, the range of these services will also include community disaster response and recovery. Disaster response and recovery activities include crisis counseling, debriefing and defusing and grief counseling. Within available resources such activities must be provided to anyone who is affected by a disaster.

**Special considerations*****Planning and services that address the needs of women***

While men and women with disabilities share many common experiences related to their conditions, systems need to recognize the fundamental differences as well. These differences are reflected in patterns of service utilization and in the life experiences of the individual. To meaningfully acknowledge these differences will require a shift away from gender-neutral service and system planning and a focus on unique needs. Systems better serve women when:

- Services are planned and evaluated with the involvement of women consumers and allied women's agencies.
- Services are provided with a holistic family-centered approach that includes services provided to children.
- Services and planning recognize consumer diversity in terms of ethno-cultural ancestry, heritage, age and sexual orientation.
- Impact of trauma/violence is acknowledged and addressed.
- Services sensitively and respectfully address issues related to sexuality, pregnancy and parenting.
- The benefits of woman-centered services are recognized, including housing and therapeutic settings in which a woman's privacy, security and social support needs are considered.

- The distinctive ways in which women experience dual conditions of mental illness, developmental disabilities and/or substance abuse are understood.
- Appropriate primary medical care is accessible for all aspects of physical health.

### ***A new look at an old standby: prevention***

There is a growing body of new knowledge about effective prevention. Much of the work on prevention effectiveness comes out of extensive research on alcohol and substance abuse, but the efforts have usefulness among all disabilities. Prevention programs are reaching a new level of sophistication that includes evidence-based practices, outcome evaluations and cost/benefit considerations. In recent years, developing and delivering prevention services and programs has become a specialty in its own right. In the field of substance abuse, the prevention specialist develops a continuum of high quality prevention services consisting of:

- **Universal prevention** – targeted to populations not identified on the basis of individual risk, such as a school curriculum and healthy living skills. (See core functions)
- **Selected prevention** – targeted to high-risk groups such as children of substance abusers.
- **Indicated prevention** – targeted to individuals with minimal but detectable signs foreshadowing substance abuse problems.

As an agency that purchases health care, the Division has an opportunity to effect change in the health status of the state by broadening the delivery system and incorporating prevention efforts alongside treatment, services and supports. Preventive interventions in physical health have been based on scientific evidence, and much has been learned about immunizations, smoking prevention and cessation, routinely covered preventive health screenings, and most recently, seat belt and helmet laws. Now there is evidence that risks also can be reduced for mental health problems, drug and alcohol abuse and physical illnesses in which onset is primarily related to behavior. By reducing risk factors and enhancing protective factors, many illnesses can be prevented or at least delayed.

As people become more informed about the effectiveness of risk reduction strategies for prevention of many mental health, developmental disability and substance abuse problems, they are more likely to demand these services. For example, individuals in recovery from alcoholism and drug addiction or those with some types of depressive disorders, may want preventive services for their children who are at high risk for similar disorders. Engaging individuals by offering a menu of activities known to promote health and wellness can increase their knowledge and involvement in making decisions to seek out and apply prescribed interventions.

The science regarding risk and protection is large, changes rapidly and varies across disabilities. Prevention programs need to build their activities on a base of evidence sufficient to justify mounting preventive interventions.

Examples from CSAT and the national Mental Health Association of the best prospects for obtaining measurable outcomes are:

- *“Prevention of initial onset of unipolar depression across the life span.*
- *Prevention of low birth weight and child maltreatment from birth to two years in children whose mothers are identified as being high risks.*
- *Prevention of alcohol or drug use by children who have an alcohol or drug abusing parent.*
- *Prevention of mental health problems in physically ill patients.*
- *Prevention of conduct disorders in young children.*
- *Prevention of fetal alcohol syndrome in subsequent pregnancies.”*

*Patricia J. Mrazek,*  
Preventing Mental  
Health and Substance

## CHAPTER 5: Structure and Management

Successful system reform depends on partnerships that reflect the best mix of public and private strengths. Systems that are wholly public or fully privatized have innate potential for failure, and neither type of system, in themselves, produces efficient results. Experience has shown that for the populations the State Plan targets, public entities at the state and local levels are designed to be more effective and efficient at ensuring public accountability, while community organizations are designed to be more effective and efficient at ensuring that services are provided. Those decisions that most directly affect consumers and families need to be made at the level of management closest to the consumer/family.

These findings, coupled with the realization that public funding will, at best, grow slowly, have implications for North Carolina's state and local systems. The state public system is challenged with providing leadership and oversight regarding the most efficient and effective application of current federal and state policy. This includes developing financial guidance and direction and regulatory and quality strategies that provide incentives for local systems to manage and implement public policy in a manner that best uses the available resources and achieves positive outcomes for people with disabilities and their communities.

The local public system is responsible for community-based planning, organizing and managing policy in a manner that best ensures conservation of resources while maximizing funds directed toward supports, services and treatments that produce valued outcomes and effective performance. County governments have a very important decision-making voice in reform. All of the counties contribute financially to the system and have an overarching interest in assuring that local systems respond to the needs of their citizens. Counties select the governance model for the LME, oversee the planning process and approve the local business plan that will be submitted for certification. On a regular basis, counties also review LME financial management

The local non-public provider system is charged with implementing policy in a manner that best uses public funds. This includes delivering best practice services and supports known to be effective and result in positive outcomes for people with disabilities. It also includes the ability to provide both direct (i.e., charitable contributions and alternative sources of revenue) and indirect

*We support the call for analysis of the fiscal impact of the proposed changes to the system, for cost modeling, and for a pilot phase of these changes, in order to gauge the true impact of the changes on the system of care, on consumers, and on quality delivery of care."*

*State Plan feedback*

augmentation of public funds through overall organizational sophistication, flexibility and a focused area of expertise that, taken together, reflects high quality performance.

Communities also have a strong role in developing and maintaining an effective local service system. The most successful systems – those with the best outcomes for people, are based on community inclusion. Community inclusion means promoting an individual’s ability to acquire and maintain desired and reciprocal peer relationships like those of ordinary people, in ordinary and natural places in the community, while also providing individually needed support and accommodations that best assure access to the opportunities and experiences of full citizenship. Development of intimate relationships, friendships, acquaintances with ordinary people, economic self-sufficiency, access and use of shared natural places, assumption of citizenship roles and responsibilities and adjustments to life transitions are key evidence of community inclusion.

## ROLE AND FUNCTIONS OF THE LOCAL MANAGEMENT ENTITY (LME)

*“The state and LMEs must be willing to go out of the lines.”*  
*State Plan Feedback*

The LME is the designated leader, responsible for managing and implementing public policy within the local public system. The LME brings together every available local resource, both paid and volunteer, into an integrated, user-friendly service system that meets the needs of people with disabilities throughout the region and is consistent with state policy. The LME focuses on stewardship of limited resources by assuring that local systems serve people with the most severe disabilities and use best practice models that have been shown to result in

positive outcomes for people. LMEs evaluate their own performance and the performance of the local system by studying system performance indicators and outcome measures and by consistent gains made through continuous quality improvement activities. The ideal LME provides no direct services, concentrating its attention on developing and overseeing service provision throughout its entire region.

Administrative functions of the LME are:

### General administration and program support

- Leadership, policy development, and overall supervision of chain of command.
- Responsibility for local business plan and its implementation.
- LME accreditation.
- Liaison with county governance and administration.

### Business management and accounting

- Monitoring and re-budgeting resources to core and target populations, savings from high cost to alternative services.
- Accounting, financial management and reporting.

- Claims processing and provider appeals.
- Services budget.
- Claims adjudication and payments (via IPRS, HIPPA compliance).
- IBNR (incurred but not reported) claims analysis; policy and procedures that govern claims adjudication.
- Personnel and training.
- Purchasing, payroll and contracts with entities other than providers in network (e.g. facility lease).

### **Screening, assessment, authorization**

(This may be embedded within routine access and emergency services)

- Conduct, screen and determine eligibility.
- Conduct assessment if person meets eligibility criteria; refer those who do not to other resources.
- Track referrals, results of eligibility assessments.
- Based on assessment, do treatment plan and authorize services.
- Formal service authorization as appropriate.

### **Utilization management**

(Not to be confused with case management)

- Define utilization management review decision points
- Develop written protocols
- Define information required for UM review
- Complete concurrent reviews (phone-based)
- Manage and respond to appeals related to UM decisions (see appeals and grievances)
- Care management

### **Information management and reporting (via IPRS and Client Data Warehouse)**

- Data warehouse and data analysis/reporting.
- Focus on performance outcomes and data-driven decision making.

### **Resource development**

- Pursue additional local, state, federal, and private funds, apply for grants, etc.
- Develop community capacity.
- Provide in-service training for staff.

### **Monitoring and evaluation - continuous quality improvement program**

(Also known as quality assurance, quality management, and program evaluation)

- Establish consumer and provider satisfaction measures.
- Analyze data for problem identification.
- Establish protocols for risk management and safety.
- Maintain quality standards in treatment and documentation.
- Demonstrate best practices for service planning supported through case management, provider incentives and technical assistance from LME.
- Develop clinical pathways.
- Train in best practice models.
- Establish individual-level and program-level outcomes and other tools to measure results.
- Give oversight of provider client outcome system.
- Carry out needs assessment.
- Review overall quality indicators of system performance.
- Review utilization trends among target populations.
- Review waiting lists and documentation of unmet needs.

- Determine clinically appropriate and cost effective alternatives to high cost services.
- Evaluate consumer and stakeholder feedback regarding system performance and need.
- Manage continuous quality improvement (CQI) system for network providers to include training, data and feedback on performance, peer review, etc.
- Review and analyze incident reports.
- Carry out on site monitoring/inspections and follow up to case manager concerns or consumer/family/community complaints.
- Investigate and respond to incidents, grievances and complaints.
- Conduct and process consumer satisfaction studies.
- Collect performance data, develop report cards for network providers.
- Conduct consumer outcome measures and analyze data for CQI.

### **Provider relations and support**

(With support from financial unit)

- Analyze network capacity (determine need, qualifications, locations and numbers of providers needed).
- Develop provider network (contracting with all providers qualified by Department's criteria).
- Develop contracts and negotiate rates.
- Define expectations, incentives, and consequences for poor performance and desired outcomes.
- Manage provider appeals (related to contracts and payments).
- Manage provider accreditation and staff credentialing.
- Oversee and monitor provider services (provider profiling).
- Provide technical assistance to providers on models of best practice.
- Provide *one-stop shopping* for providers (licensure, advocacy with other state agencies, etc.).

### **Consumer affairs and services**

- Assist consumer empowerment and advocacy.
- Manage complaints, appeals and grievances.
- Assist consumer advisory board.
- Provide consumer education for rights, advocacy, grievances and appeals.
- Assist recovery, self-determination, self-help and empowerment support systems.

### **Community core services**

#### ***Community coordination***

- Monitor individual case coordination done by case management.
- Provide collaboration and planning opportunities.
- Coordinate of system of care among agencies.
- Conduct formal interagency meetings as required by the state.
- Provide community education/prevention activities.
- Provide consultation.

#### ***Information and referral***

- Answer phone calls and provide referrals as appropriate.
- Maintain database of callers' concerns and inquires.

#### ***Emergency Services***

These range from 24/7 on-call back-up support of local emergency system to walk-in centers and/or mobile crisis teams.



## Case Management

(A service function).

Models of direct case management including client specific support coordination and service brokerage. This is not system service coordination.

## SYSTEM TRANSITION ISSUES

The state reform effort requires each area program and county to move forward to develop an LME in a single or multiple county authority or county program. This effort allows local public systems an opportunity to determine the pace, within a three-year time window, to proceed with their certification as an LME. These developmental efforts are reflected in the local business plan (LBP).

Local business plans developed by each LME will provide the basis for transition to the new system. These plans will state clearly the transition steps and timeframes that will lead their specific geographic areas to full implementation. It is understood that reforming the entire system must take place over a period of several years. Services to consumers and their families must not be disrupted by missteps in the implementation process. The first important responsibility of the LME will be to manage the local change process effectively.

Specifications for developing local business plans are contained in elsewhere in this State Plan. Local business plan design intentionally provides for designation of ongoing planning and implementation strategies to facilitate a smooth and thoughtful transition process. In addition, it is anticipated that each local area will produce a plan that prioritizes development of the various components to best meet the unique strengths and needs of the communities it will serve. All local business plans will include the following:

- A mission and values statement conforming to the State Plan.
- Focus on consumer/family and citizen involvement in all components.
- Emphasis on practice platforms and models of best practice consistent with the State Plan.
- A three-year strategic plan that includes performance goals, objectives, strategies, specific outcomes and timelines for completion.
- A plan for development of a qualified provider network.
- A methodology for providing and overseeing core functions and management of the system of services/supports to target populations.
- Financial accountability mechanisms in compliance with the intent of the reform statute and the State Plan.
- Evidence of technological capacity to meet state standards for data collection, reporting and other management information system requirements.

- A detailed quality management plan that ensures compliance with the statewide system components.
- User-friendly and consistent access processes and procedures in accordance with state uniform portal specifications.

The process for submitting and approving local business plans is contained in the local business plan section of this State Plan. There are provisions for submitting information at various stages of the process in order to provide the flexibility necessary to ensure an orderly statewide transition to the new system. The state strategic business plan, described in a technical document of the State Plan requires activities at the Division level for assisting in local planning efforts and negotiating individual issues to meet unique community needs through the transition process.

A significant number of area/county programs have indicated interest in participating in the first phase of State Plan implementation. Many of these prospective LMEs have already initiated their planning processes, and they are pursuing creative and innovative ideas. In an effort to facilitate transition and to share what is learned - both successes and challenges - the Division has asked these first programs to come together as a group to lead the transition. State staff and staff of the NC Council of Community Programs and the NC Association of County Commissioners will participate in this transition endeavor and will share information learned with all of the stakeholders in system reform. It is anticipated that the work of this phase-in-group (PIG) will inform future revisions of the State Plan, local business plan specifications and the state business plan as we move forward.

### **Individual transitions**

There are a number of individuals being served by the current system who do not meet eligibility criteria for a target population. These people will be assisted to move to other alternatives within the system over a clinically appropriate but reasonable length of time. There are many community groups and organizations across the state that have long histories of helping people who need human services and supports. The LME will promote and encourage membership of these organizations in the local provider network. These agencies who give so much to their communities will be important and respected partners in the statewide effort to provide services to the people who need them. Members of target populations who are already receiving services but whose care, services and/or supports substantially exceed those indicated for their level of disability, must be reevaluated and the level of supports realigned in order to free up resources for others who are equally or more in need of services.

### **Community resources for non-target populations**

Through a needs assessment process, LMEs identify generic community resources and other resources needed in the community. Generic community resources may include medical services, nutrition services, transportation, local employee assistance programs, self-advocacy groups such

as VOICES for Addiction Recovery, NC Mental Health Consumers' Organization, the North Carolina National Alliance for the Mentally Ill (NAMI-NC), substance abuse support groups and consumer groups, etc.

### Provider network transitions

Area planners in nearly every region may find that the number and type of private providers currently available are insufficient to meet identified needs. Local business plans will include an assessment of the current available resources and a transition plan for developing a qualified provider network that delivers the full range of services needed in the amounts required. The local business plans will include specific strategies for building a qualified provider network and ancillary efforts necessary to minimize the impact of gaps in the network.

## QUALIFIED SERVICE PROVIDER NETWORKS

### Consumer choice

Making sure that consumers have choices of services/supports and service providers is one of the driving forces behind the reform movement. People with disabilities need to be able to *select* their providers, services and supports, and also to *select* different ones if they find that their original choices are not satisfactory.

*"The system needs to be more sensitive to what the consumers and families want. The families need more say."  
State Plan Feedback*

*Choice* can be looked at along two dimensions. First is the number of active providers in the network. Adequate networks will include a range of providers in each service or specialty so that people may choose from among them. In rural areas where there are very few providers, LMEs must work actively to build their network over time. The network will be considered *adequate* only when opportunities for consumers and families to exercise informed choice are fully present. The option to choose is especially important when the provider works very closely with individuals on a frequent and ongoing basis. Case management and personal care services are examples. LMEs, whether they provide or contract for such services, must assure that individuals may select different people and providers if they so choose.

The second dimension of choice relates to the richness of the service and support array in the regional system. Emphasis here is on a continuum of options that corresponds to the levels of service people want and need. For example, it is preferable to have a single agency that develops three levels of supported housing/residential programs than to have three agencies that provide one single level. A person with a disability should not be forced to choose a group home when he/she is capable of living more independently. Neither should anyone be forced to opt for day activities that are static or not stimulating simply because nothing else has been developed. To provide a more robust service/support array LMEs may need to look at sharing resources and going across area/regional boundaries to enhance the availability of options. In addition, the local system must

evolve in a manner in which people with disabilities, allied with others who care about them, may not only choose from among available services, but will have the opportunity to compose their own supports and services as well. The system must sustain a viable mix of services and supports. Again, developing a full array may need to take place gradually but it must be an integral part of all regional planning.

## **Network development**

This section responds to requests for additional clarification and information on provider network development. Questions have focused mainly on issues relating to the selection and numbers of providers to be admitted, that of LMEs acting as both regional manager and direct provider of services and guidance for LMEs divesting themselves of direct service provision.

### ***Network membership***

Department secretary Carmen Hooker-Odom has stated publicly that providers who wish to receive public dollars – Medicaid or state – *must* join the local provider network. While this policy provides a helpful incentive for providers to participate in the new system, it also places an obligation on the LME to admit qualified providers who wish to join. Providers who are already receiving public reimbursements or those who elect to participate at a later date may not be excluded as a way of limiting network size. This applies primarily to single or group practitioners who are reimbursed on a fee-for-service basis and does not establish an obligation to provide a pre-arranged number of referrals.

Services or programs such as habilitation or rehabilitation programs, supported employment services, emergency/crisis systems, agencies that provide ACT programs, and similar service/program categories, lend themselves best to contracted arrangements. When determining the necessity and quantity of the service/program, the LME should ensure that:

- Models of acceptable practice are defined.
- Scope *and* economies of scale are considered.
- Cost parameters per service category have been determined.

Once these factors have been agreed upon, recruitment and selection may be handled by issuing requests for proposals and awarding contracts to the best applicants. The selection process must include participation and recommendations of people with disabilities and their families. All such contracts shall be re-bid at least every three years.

### ***LMEs as direct providers***

The ideal LME provides no direct services. Rather, the LME devotes its attention to managing and coordinating the array of services and supports across the entire region. However, every region has unique characteristics - greater or lesser numbers of potential network members, the presence or absence of specialty service providers or any number of other factors that impact local transition to the reformed system. Therefore, decisions about the LME providing direct services have to be

made on a case-by-case basis, considering the specific circumstances. Factors to be weighed include:

- Efforts expended by the LME to attract and retain an adequate private provider network.
- Possible divestiture of current area program clinicians to a private, non-profit arrangement.
- Level of community support for the LME to continue providing some services pending development of an adequate network.

### ***Service delivery divestiture options***

Some area programs (APs) have initiated efforts to *spin out* (movement of AP direct service staff to existing provider organizations) and/or *spin off* (movement of AP direct service staff to newly developed provider organizations) as part of an overall strategy of developing a sound and comprehensive competitive provider network. The rationale behind these efforts is:

- To ensure that transition efforts are not disruptive and/or create a break in services for people with disabilities who are currently being served. This includes preventing a full-scale comprehensive shift in staff delivering services at a single point in time.
- As a mechanism to provide opportunities for staff to remain employed in the field, including increasing their certainty of future employment. This is particularly intended to minimize an increase in staff turnover and the corresponding problems in service delivery during the state reform transition timeframe.

These practices are acceptable. However, they must adhere to the following conditions:

- They shall neither inhibit nor relieve the AP (prospective LME) of their responsibility to aggressively and continuously recruit and retain a competitive and comprehensive provider network.
- This effort shall be only a part of the overall strategy to build the provider network.
- The AP (prospective LME) shall have no tie to these organizations that is unlike the ordinary relationship it would have with any other provider organization. For example, the AP (emerging LME) director may not be on the organization's board of directors.
- These organizations shall be legally freestanding organizations.
- The transfer process shall not place these organizations at an unfair advantage over any other provider organizations.
- Every and all components of the transfer and transition shall not create an immediate or future unfair advantage over other provider organizations.

- The organizations shall be expected to compete in an equal and fair manner with all other comparable entities, in terms of services provided, provider organizations that are in the network at the point of transfer and into the future.
- As shall be expected of all provider organizations, these organizations shall be required to shift practice expectations to the expectations of the state agency purchasing services through the LMEs. If service practice expectations as well as quality, effectiveness and efficiency expectations are not met (outcomes, systems performance and regulatory compliance), these organizations shall be treated equally and suffer the same consequences as any other provider organization.

Emerging LMEs who divest any or all of the services they currently directly deliver through recruiting suitable provider organizations, must develop transition plans for the orderly transfer of service components. These plans are to assure that there is no disruptive break in service and that the people being served are fully informed and supported in their transition to the new arrangement.

### ***Qualified service provider network/direct enrollment***

Widespread comment has been received requesting both expansion of direct provider enrollment and ending direct enrollment. Currently, directly enrolled providers submit billings and receive reimbursements for Medicaid covered services directly through the Division of Medical Assistance (DMA/Electronic Data Systems (EDS) rather than via area program claims management processes. The advantage to the provider is faster reimbursement for services by eliminating the middle step – the area program. The advantage to the area program is that directly enrolled providers bill using their own Medicaid provider number rather than that of the area program, thus, reducing the area program's liability for payback if inaccurate billings are submitted by providers.

With the rollout of the IPRS system underway, direct enrollment can now include reimbursement for state funded services as well. The State Plan implementation committee on quality of care established a workgroup to study the issue of direct enrollment and provide recommendations. The group's report is currently under review. Whether or not direct enrollment is eventually expanded, all providers in the network will be subject to the same LME referral mechanisms and utilization management criteria and procedures regardless of the payment source.

Direct enrollment requirements in the future will be linked with licensure and performance of quality indicators. The ability to meet outcomes will be used to measure performance and eventually will be linked to payment of services. This shift has many implications and will be one of the final steps of implementation. As an interim step, reports of qualified provider performance will be published and will be an integral part of educating individuals and families about selection of qualified providers. These reports will also be used as a factor in examination of qualified provider rates.

Memoranda of agreement (MOA) will be required of all members of the LME's qualified provider network. This will include all directly enrolled qualified providers who make services available to target populations, including ICF/MR group homes, adult care homes and state operated services. A standardized MOA is currently under development and nearing completion.

## DEPARTMENT COORDINATION AND INFRASTRUCTURE

### Division leadership

The Division of Mental Health, Developmental Disabilities and Substances Abuse Services has new leadership. Richard Visingardi, Ph.D. began his tenure as the Division's director on February 4<sup>th</sup>, 2002. A Division reorganization plan has been designed to more closely support and facilitate implementation of the State Plan and the reformed system. The reorganization plan includes advocacy and customer services.

This State Plan requires changes in Division practices, leadership methods and business functions. Division staff will need to develop new/different sets of skills to meet the challenges of system reform and to be effective leaders in the new system. Just as providers in the regional networks will expect the LME to effectively manage regional issues and be responsive to problem areas, LMEs must be able to look to the Division for leadership and technical assistance in developing the new regional systems. They will also expect dissemination of clear and concise Division policies consistently applied throughout the system. An overview of the Division reorganization is included as a technical document in this State Plan revision.

### Intra-Departmental coordination

Department divisions are working together to develop and revise programmatic policy and to address administrative and business functions. Particular attention is being paid to areas in which multiple divisions and departments work on similar issues, such as health, employment, housing and transportation. The Division of MH/DD/SAS, Division of Medical Assistance, Division of Facility Services and Public Health are organizationally located under the Assistant Secretary for Health and, as such, are working on several joint initiatives. These divisions are specifically looking to enhance coordination in the areas of financing strategies, case management protocols and best practice models to make maximum use of funding opportunities. Although much work remains to be accomplished, progress is being made to promote coordination.

Another major area of cross-Departmental coordination rests in the long-term care cabinet, appointed by the Department secretary in 2001. All divisions with interest in long-term care are together exploring policy unification of issues ranging from provider qualifications to self-determination. The Office of Long-Term Care, which staffs the cabinet, manages the Real Choice Systems Change Grant received from CMS to improve the quality and stability of the direct care work force. The Department has received two additional Systems Change Grants, one focused on consumer-

directed supports (Community PASS) and the other to promote nursing home transition. The Division manages the Community PASS project, but all of the grant work is being coordinated through the Office of Long-Term Care. Another component of this effort is development of a coordinated strategy for integrating the Olmstead, long-term care and state mh/dd/sas plans.

In addition to coordination across Department divisions, the Division of MH/DD/SAS must work across departments on several fronts. *State Plan 2001, Blue Print for Change* called for a study to effect improvements in advocacy and ombudsmen operations. This effort has included the Governor's Advocacy Council for People with Disabilities within the Department of Administration as well as several other Department divisions. There are many other cross-Departmental initiatives necessary for implementation of the State Plan, including work with the Department of Corrections, Department of Juvenile Justice and Delinquency Prevention, Department of Transportation, university and community college systems, and the federal Housing Finance Agency. The state strategic business plan addresses specific collaboration tasks and strategies, many of which are already underway.

## DOCUMENTATION

Reporting requirements currently in use are under review to determine whether they have continuing legitimate value for the new system. Necessary documentation requirements include service records, federal reporting requirements, financial management activities including information needed to process and settle service claims, statistical data intended to measure system outcomes and performance and others.

A task force within the Division has been revising the service records manual for area programs and contract agencies (APSM 45-2) since autumn, 2001. The group has completed the revision and forwarded its recommendations to Division management. The manual will go into effect upon final approval. Qualified providers/agencies are accountable to the people they serve, to their communities and to their funding source. Such providers assume liability for the quality of their records. Local managing entities will be responsible for ensuring that qualified providers receive accurate and timely information. The Division and/or Department will distribute materials to directly enrolled qualified providers.

Documentation is also essential for billing services to third parties (insurance companies, government agencies, etc). Third parties may arrange for periodic audits to ensure that they are getting what they pay for. Records and charts will be examined during audits along with other relevant information and data. Public and private agencies will be audited using the same standards and criteria except as mandated by federal or state law and rules. Results of Division audits, monitoring visits or investigations will be published within 45 days of review and will be used for quality management activities and reports cards.



The Division, however, is mindful of the widespread concern about the burdens of excessive documentation and reporting. While reporting requirements change over time as service and management processes change, the system needs to make documentation requirements as flexible and simple as possible and discontinue what is no longer necessary. The Division will promote the use of technology to expedite documentation and reporting procedures and will look for ways to consolidate functions throughout the Division and Department to minimize paperwork at the local level. As we evolve to an outcome-based system, quality assurance activities will significantly decrease their reliance on paper reviews.

## LICENSURE AND MONITORING SERVICES

The Division monitoring workgroup has completed a draft of a working model for system monitoring under the State Plan. This report is under review. Assumptions and priorities used by the monitoring workgroup were explicitly derived from the State Plan and additional considerations established by the workgroup. The monitoring component of the State Plan has an identified deliverable date of October 1, 2002.

These components included:

- Stewardship of state resources.
- Statewide consistency through statewide oversight and inter-rater reliability.
- No duplication.
- Family/consumer involvement.
- Outcome-oriented.
- Participant-driven and person-centered.
- Data collection priority.
- State-established monitoring criteria.
- Licensure of all services.
- Routine monitoring centers at LME, using a QI/corrective action approach.
- State monitoring of items identified as trigger issues.
- Accountability to all federal and state rules and laws

The Division of Facility Services (DFS) is the regulatory agent for state oversight of licensed services. DFS will be responsible for conducting inspections for compliance with licensure requirements. Results of these inspections will be published and used as quality indicators for performance.

The LME will monitor qualified providers within the network. Local monitoring will focus on the quality of clinical and programmatic delivery and will not be considered a licensure inspection. The monitoring workgroup is developing standardized monitoring protocols and criteria.

Licensure for professional practitioners will be used as an indicator of qualification for service. Direct enrollment will be evaluated for all licensed practitioners. In the future, qualified providers of non-facility based services will be subject to licensure or compliance with identified standards.

## STATE AND LOCAL CONSUMER AND FAMILY ADVISORY COMMITTEES

Each prospective LME will establish a consumer and family advisory committee (CFAC). The CFAC will convene at the beginning of local planning efforts and will have an active role with delineated responsibilities throughout the planning process. The group will advise staff regarding the local planning effort and will review and submit a separate report(s) on local business plans to the Division.

The CFACs will have clearly specified relationships to county/area boards as described in local business plans. Each local advisory committee will be staffed by an employee of the LME whose responsibilities will include:

- Obtaining consumer and family input from the community.
- Carrying forward recommendations of the advisory committee for implementation.
- Serving as liaison to the state advisory committee and other local agencies, organizations and associations.
- Recruitment of initial members of the local advisory committee in collaboration with local consumer and family advocacy organizations.

The Division will convene a CFAC that is composed of representatives of the local committees. The composition of both the state and local CFACs will reflect:

- 100 percent consumers and family membership.
- Equal representation of all disability groups.
- Membership representative of the race and ethnicity of the community.
- Representation for each disability group including a man, a woman and a youth member. (Family members may represent children. A parent may represent the needs of parents of adult consumers, but may not represent adult consumers.)

Roles and responsibilities of the state and local advisory committees will be established according to specifications outlined in the state strategic and local business plans. They must be consistent with the principles of the State Plan and address the following:

- Advise and comment on all state and local plans.
- Recommendations on areas of service eligibility and service array, including identifying gaps in services.
- Assist in the identification of under-served populations.
- Provide advice and consultation regarding development of additional services and new models of service.

- Participate in monitoring service development and delivery.
- Review and comment on the state and local service budgets.
- Observe and report on the implementation of state and local business plans.
- Participate in all quality improvement activities, including tracking and reporting on outcome measures and performance indicators.
- Ensuring consumer and family participation in all quality improvement projects at both the provider and LME levels.

The state strategic and local business plans, technical documents of the State Plan, provide for the creation of a support system at both state and local levels to ensure consumer/family participation and viability of the CFACs. The support system will include consideration of the following:

- Stipends as appropriate to ensure participation.
- Transportation or compensation for travel expenses.
- Childcare and eldercare if needed.
- Flexible scheduling of meeting times.
- Information and education regarding the service system, including funding sources, the system for access and service availability.
- Materials regarding system reform practice platforms and models of best practice.

## **APPEALS, GRIEVANCES, HUMAN RIGHTS, CONSUMER ADVOCACY**

The reform statutes require a wide range of activities to ensure fairness, consumer choice, consumer rights and protections, individual and system advocacy efforts and effective quality management. There are also a number of existing avenues to address appeals, client/human rights and advocacy. An implementation workgroup of consumers was convened to study the possible benefits of consolidating these activities. This study has, for the first time, identified all of the advocacy and ombudsman efforts throughout the Department and found that they are more numerous than first anticipated with a scope that has grown proportionately. The workgroup prepared an interim report for the Division director and the Department secretary this spring. A second progress report with limited recommendations has recently been submitted and is under review. Final plans must be approved by the Department secretary and will be presented to the LOC.

## **TRAINING**

Training and technical assistance are fundamental to the reform effort and will become an integral component of all Division work. Education and training efforts at the state level will be coordinated within the Division and across the Department. The state strategic business plan outlines a significant collaboration effort to include all training venues in the state to expedite reform. Local business plan specifications include a variety of training activities that will be the responsibility of the

LMEs. State and local training, information, education and technical assistance will be directed to the many stakeholder audiences and will address all aspects of system reform. All of these activities will be conducted consistent with the principles in the State Plan and will:

- Reflect the latest research, best practices and state-adopted practices.
- Positively affect consumers and their families.
- Be self-sustaining to the extent that individual training efforts are part of larger plans and continue on a regular basis.
- Be accessible throughout the state or region as appropriate.
- Increase local capacity to provide services and supports.
- Result in permanent workplace change.
- Be sensitive to all cultures.

## INFRASTRUCTURE

### **Collection and analysis of data**

A variety of data will be collected and analyzed for purposes of planning, establishing benchmarks, measuring individual and system outcomes and informing decision-making. All area/county programs and other qualified providers shall participate fully in the state's efforts to study and evaluate system components. However, the state must also be mindful of the need to eliminate unnecessary reporting requirements and avoid excessive documentation rules for providers.

### **Integrated payment and reporting system (IPRS)**

Three reporting and payment systems now used are being replaced by the Integrated Payment and Reporting System (IPRS). Also underway is a project to implement a decision support information system. IPRS uses internet and mainframe technology and is part of a major effort to upgrade the Division's management and information system. The IPRS will be used by the Division to process, track, pay and report on all claims submitted by providers for services rendered to its constituent population. Its implementation will solve problems in current unit cost reimbursement systems by allowing LMEs to submit a single claim to the state and receive payments from the proper funding source, including Medicaid, MRMI Services, At Risk Children's Program, Pioneer and capitated risk contracts. It also provides many significant new capabilities in the areas of utilization management and tracking and reporting services to consumers. The system provides the Division and IPRS end-users with the following advantages:

- Provides an opportunity to modernize important business functions
- Provides a sound basis for purchase of services
- Establishes central consumer and provider databases
- Reduces duplicate billings and payments
- Ensures Medicaid is the first payer

***IPRS implementation timeframe***

Two area programs, Duplin-Sampson-Lenoir Area Program and Southeastern Center, have served as pilot sites for the new system, which is scheduled to begin statewide rollout on July 1st, 2002. The first step in using IPRS is determining the individual's eligibility for public services; that is whether the person is a member of a target population. Since the target populations have been adjusted based on widespread feedback, work to incorporate the changes may delay the rollout by a few weeks. Implementation is expected to occur in four phases according to the following schedule. This schedule is subject to change, however, depending on LME configurations and mergers selected by the counties:

**Phase 1** Guilford Center for Behavioral Health and Disability Services; New River Behavioral HealthCare; Pathways MH/DD/SA; Smoky Mountain Center for Mental Health, Developmental Disabilities and Substance Abuse Services; Vance Granville Franklin Warren Area Authority; Wayne County Mental Health Center

**Phase 2** Lee-Harnett Area Mental Health, Developmental Disabilities and Substance Abuse Authority; Mecklenburg County Health, Mental Health and Community Services; Orange-Person-Chatham Mental Health, Developmental Disabilities and Substance Abuse Authority; Sandhills Center for Mental Health, Developmental Disabilities and Substance Abuse Services; Southeastern Regional Mental Health, Developmental Disabilities and Substance Abuse Services; The Durham Center Tideland Mental Health Center; Wake County Human Services; Wilson-Green Area Mental Health, Mental Retardation and Substance Abuse Services

**Phase 3** Alamance-Caswell Area Mental Health, Developmental Disabilities & Substance Abuse Authority; Albemarle Mental Health Center & Developmental Disabilities & Substance Abuse Services; Blue Ridge Center for Mental Health, Developmental Disabilities & Substance Abuse Services; Crossroads Behavioral Healthcare; Cumberland County Mental Health Center; Davidson County Area Program for Mental Health Developmental Disabilities & Substance Abuse Services; Johnston County Area Mental Health, Mental Retardation & Substance Abuse Authority; Mental Health Services of Catawba County; Centerpoint Human Services; Onslow County Behavioral Healthcare Services; Neuse Center for Mental Health Developmental Disabilities & Substance Abuse Services; Piedmont Area Mental Health, Mental Retardation, & Substance Abuse Services; Randolph County Mental Health Developmental Disabilities & Substance Abuse Program; Roanoke-Chowan Human Services Center

**Phase 4** Edgecombe-Nash Mental Health, Developmental Disabilities & Substance Abuse Services; Foothills Area Mental Health, Developmental Disabilities & Substance Abuse Program; Pitt County Mental Health Developmental Disabilities & Substance Abuse Center; Riverstone Counseling & Personal Development; Rockingham County Area Mental Health Developmental Disabilities & Substance Abuse Program; Rutherford-Polk Area Mental Health, Developmental Disabilities &

Substance Abuse Authority; Trend Area Mental Health Developmental Disabilities & Substance Abuse Authority

## **System quality management plan**

Quantity or adequate provision of a particular service or compliance with a specific regulation is *not* a measurement of outcome. These measures may indeed provide necessary information to manage systems; however, the ultimate measurement of outcomes is related to real life changes for people with disabilities and the system's performance relative to those outcomes.

Outcomes fall into four broad categories:

1. Changes in the quality of an individual's life. These include measurements throughout all life domains - cultural, educational, vocational, financial, living arrangements, spiritual, relationships, recreational, as examples.
2. A person's satisfaction with his/her life as well as the supports and services he/she is receiving, including an evaluation of the proper application of person-centered planning.
3. Negative life events such as episodes of residential instability and homelessness or incarcerations in jail.
4. The costs associated with achieving real life outcomes including factors such as level of satisfaction and the possible occurrence of negative events.

The aggregate measurement of outcomes, taken along with regulatory compliance and application of best practice and emerging best practice in administrative, management and programmatic roles, provides a composite of overall systems performance.

System-wide quality management and continuous quality improvement focused on achieving positive outcomes for the people served provides vital information both to state and local systems and to system stakeholders - people served, families, advocates, legislators and taxpayers - about system performance in a practical, realistic way. Measuring outcomes also allows the system to compare itself with other, similar states that are tracking many of the same outcomes. Finally, tying quality and continuous improvement efforts to real life outcomes for people gives new meaning and importance to uncovering system weaknesses that provide opportunities for improvement.

The quality management system must also strive to continuously move the system toward emerging best practice. It is this component of the mh/dd/sa system that will remain aware of ongoing

research, new medications, improvements in treatment techniques and evaluative processes for determining the effectiveness of the system. Research has given us a better understanding of the disease of addiction and has led to improvements in treatment techniques. Recent research has focused on development of medication that reduces craving for opiate and cocaine addicts, as well as comparisons of psychotherapy techniques to determine which treatments or preventive interventions are most effective for which consumer groups. The development of new medications in recent years has also significantly improved the outcomes for many persons with severe and persistent mental illness. Medical research and development of assistive technology have greatly improved quality of life for many individuals with significant physical and cognitive disabilities. All of the State Plan's target populations have witnessed the positive effects of applying emerging best practice with ongoing evaluation.

The public service system must find ways to bridge the gap between research and practice. Examples of North Carolina's efforts include the National Institute on Alcohol Abuse and Alcoholism (NIAAA) *Researchers in Residence* Program, the National Institute on Drug Abuse (NIDA) Clinical Trials Network Initiative, and the Center for Substance Abuse Treatment (CSAT) Practice Improvement Collaborative. The Division supports research as a collaborative effort between our state facilities and the university system. The result of much of that research is published nationally and put into practice throughout our state. The state strategic business plan includes tasks and strategies to increase our awareness and application of emerging best practices.

### **Report cards**

The new system needs to be one in which success is acknowledged and celebrated and shortcomings are identified and dealt with. Periodic report cards on system performance in achieving positive outcome goals will be published on a regular basis. The first of such report cards will be published in July 2004.

*"LOVE the report cards!"*  
*State Plan feedback*

## **STAFF COMPETENCIES, EDUCATION AND TRAINING<sub>c</sub>**

Competency-based system for qualified service providers is in development. Its purpose is to raise the level of quality and consistency statewide for delivery of services to people with disabilities and to achieve measurable outcomes. This effort is consistent with the national move toward competency-based requirements for billable services. Recognition is also given to those licensing and certification boards already in place and serving people with disabilities well.

The current design includes seven core skill areas required to meet minimal standards for a competency-based system for staff services in North Carolina:

- |                         |                          |                     |
|-------------------------|--------------------------|---------------------|
| 1. Technical knowledge. | 4. Decision-making.      | 7. Clinical skills. |
| 2. Cultural awareness.  | 5. Interpersonal skills. |                     |
| 3. Analytical skills.   | 6. Communication skills. |                     |

Several implementation phases are necessary to build a solid, cost effective, stable system that will achieve measurable objectives. The rewards of a competency-based qualified provider system can be:

- Better personal outcomes for people with disabilities through more stable support systems.
- Less staff turnover and reduction of associated costs with replacing and training new personnel.
- Reduction in administrative costs through standardizing qualifications and competencies for professionals and paraprofessionals.
- Improved professional ethics and standards.
- Higher morale and more motivated employees.
- Streamlined, cost effective statewide standardization of qualification and documentation processes for professionals and paraprofessionals.
- Improved quality outcome indicators that can be measured against national standards (accident injury rate, staff turnover, etc.).

Determining staff competencies and applying them consistently across the state and among all disability groups is a difficult task. This task is complicated further by movement of the system to one that is consumer-driven and provides more flexible options. Prior to implementing the system statewide, the Division will assess the cost benefits of such a system as well as any measurable impact on quality.

### **Rules adoption and statute revisions**

The *State Plan 2001: Blue Print for Change* included a report on rules and statutes in need of review to determine if the existing regulatory framework supports the reform effort. An implementation workgroup on rules coordination has developed a streamlined process to ensure that existing rules undergo review and amendment, if necessary, and that proposed rules are reviewed for consistency with the reform effort and among divisions and Department. This work will include clarifying processes for establishing Division policy, regulation, standards, rules and statutes and differentiating among these provisions. Consumers and families, through their membership on implementation committees and workgroups, provide recommendations on the need and substance of regulatory reform.

This spring, the sub-committee of the Legislative Oversight Committee (LOC) focusing on the Commission for Mental Health, Developmental Disabilities and Substance Abuse, raised concerns about multiple rulemaking bodies and processes throughout the Department. As a result, the LOC put forth draft legislation requiring the Department to establish a rulemaking process that eliminates duplication and overlap and that identifies rules that are in conflict or are redundant among the various rulemaking bodies within the Department. The Department will take this opportunity to continue its review of rules for vagueness, duplication and ambiguity. In addition to reviewing existing rules, the Department will issue new rules, policies, standards and/or regulations to promote reform and a coordinated system of care. The Division of Medical Assistance (DMA) and the Division of MH/DD/SAS will cooperatively plan any policy or rule making in order to meet the



mission of a unified system and to meet statutory requirements of both agencies for rules and policies.

This plan requires realignment of nearly all of the regulatory components within the system in order to implement reform and provide an array of services/supports/treatments consistent with best practice platforms for targeted populations. The Division has initiated review and will pursue amendments or modifications to the following, as necessary:

- Service definitions and standards.
- Management information system requirements.
- Licensure rules, regulations and practices.
- Documentation requirements.
- Clinical care guidelines and protocols.
- Medical necessity criteria.
- Monitoring requirements and performance criteria.
- Readiness requirements and review procedures for LMEs certification.
- Competency requirements for staff.
- Fiscal rules, policies and procedures, including audit guidelines and rate setting.

## FINANCE STRATEGY

Like many other states, North Carolina is experiencing an economic downturn and is struggling with a financial crisis unmatched in recent history. Balancing the state's budget will require far more than a temporary belt-tightening. Forecasts for next year offer little hope of a quick recovery. This is a particular challenge facing the state reform and plan efforts.

The current finance strategy revolves around a single practice – billing. A fee-for-service strategy is just that – provide a service and receive a fee. Best practice finance strategies are evolving around the nation. These strategies all link management of funds with expectations identified in this plan, including linking state facility usage to community funding and best practices. Although North Carolina's specific strategy is not fully complete, it seems highly unlikely that the future will be financed only through a fee-for-service system.

The budget crisis must affect the manner in which finance strategy is developed. The overall strategy must be developed with the more immediate budget crisis and related tactical concerns in mind. At the same time, these tactical considerations require two characteristics: first, the need to reflect the opportunities inherent in a budget crisis; and second, the need to be consistent with elements of the strategy that will roll out over the next several years.

The role of the LME is key in the management of public funding. It is related to the ultimate finance strategy intent of: (a) expectations of exemplary LME systems performance, (b) clearly

identifying and justifying indirect costs of public local management, and (c) increasing availability of funds for direct supports, services, treatment and care. Reductions in prescriptive practices will result in reduced indirect spending and burdens on direct service provision with an ultimate real and residual increase in the direct provision of services.

Achieving public policy objectives requires a corresponding finance strategy that provides the necessary incentives and disincentives that bring about behavior changes critical to meeting public policy expectations. This includes shifting reliance on expensive institutional care and the fixed costs associated with maintaining facilities that perpetuates an outdated service delivery model and drains the system's limited resources.

To this end, the state reform and Plan have three key public policy expectations as foundations of the finance plan. The system must be:

- Consumer-driven and person-centered.
- Accountable for its stewardship and performance.
- More efficiently managed.

To support these three policy expectations, a finance strategy must provide the necessary incentives and disincentives that effect behavior critical to the achievements of the mission and vision and policy. Although these policy expectations are explained more fully in early sections of the State Plan, listed below are descriptions of their impact upon the financing plan.

### ***Consumer driven***

**Expectation #1:** The ultimate finance strategy will be tied to expectations that the system is consumer driven.

A consumer driven system is characterized as a demand-oriented market, meaning the consumer decides what type of service/supports are needed, and the provider system meets the demands. This is different than the current system in that consumers are told what services are available, and they are *fitted* into slots or vacancies, even if it is not the best or most efficient option. A consumer driven system defines the consumer as the intended direct beneficiary and the public as the intended indirect beneficiary. The system is the residual beneficiary, meaning it is financially rewarded for providing supports, services, treatment and care in a consumer driven publicly accountable market. It should also be noted that as this involves the use of public funds, consumers are responsible purchasers. Therefore, the ultimate finance strategy will be tied to expectations that the system is consumer driven.

It is expected that an informed and responsible consumer driven approach to systems development will promote an increase in both the efficient and effective use of public funds.

### ***Systems performance***

**Expectation #2:** The ultimate finance strategy will pay for expectations of systems performance.

Simply regulating systems and monitoring for regulatory compliance only provides a limited view of the performance. In fact, excessive and ill-defined regulations and monitoring may in themselves be inefficient. Overall performance relative to intended measures of performance and outcomes such as penetration rates, consumer-related outcomes, etc., is the comprehensive measure of systems. Therefore, the ultimate finance strategy will pay for expectations of systems performance.

It is expected that a system designed and managed in performance will find diminished management related costs such as indirect costs associated with agency administration and program management at the state and local levels and in the public and private sectors.

### **Accountability**

**Expectation #3:** The ultimate finance strategy will not assume a complete *free market* approach to assure efficiency.

Each of the system entities — public entities, non-profit organizations and for-profit firms — brings strengths with the roles they have been assigned in the State Plan. Systems performance, delegation of roles and competition are examples of exemplary practices associated with systems accountability in a system that is consumer-driven. However, a public mh/dd/sa system is not a true market driven system. Therefore particular policy interventions are intended to promote a more market like atmosphere. These interventions are intended to promote the public trust and ensure the most efficient use of resources as a financial incentive structure. Therefore, the ultimate finance strategy will not assume a complete *free market* approach to assure efficiency; it will, however, contain sufficient and efficient attributes to promote accountability.

It is expected that an accountable system built upon a consumer driven and systems performance focus will ultimately result in increased availability of resources to be provided for effective, efficient, quality and needed direct supports, services, treatment and care. Administrative costs must be aligned with the purposes of the overall management strategy.

The State Plan outlines seventeen specific strategies designed to move the system forward while dealing with the reality of the current budget situation. They are organized below by their content areas and by the timeframe during which they will be implemented.

### **SFY 02/03: Demonstration of competency and foundation building**

The budget crisis creates an opportunity for the system to demonstrate leadership and fiscal and management competencies. These competencies are also necessary in the evaluation of readiness to implement the State Plan. The focus of SFY 02-03 will involve state, local and provider systems being provided an opportunity to demonstrate competencies that will be required over time. These efforts are also intended to provide practice clarity necessary for the completion of the local business plans (LBPs). Additionally, these efforts are intended to build a fiscal foundation regarding practices, in which resources are arranged and base revenues are necessary for future financing

innovations. These efforts are intended to mitigate budget reductions. Finally, the efforts of SFY 02-03 are intended to set the course for all future financial strategy plan development. Along with the State Plan revisions offered in this document, there are several products that will be delivered by the Department in SFY 02-03 to provide direction and clarity. They are:

### ***1. Coordinated realignment of funding***

**Objective:** A funding strategy that supports reform with a course set in 02-03.

This component of the Plan provides initial detail of SFY 02-03 finance strategy planning and constructs the framework for the continuous evolution the strategy. Coordinated by the assistant secretary of health and in conjunction with the deputy secretary, an inter-Departmental team consisting of the Division of MH/DD/SAS, DMA, office of policy and planning, office of budget and financing and controller's office will be responsible for full conceptual-to-technical development of the finance strategy. Other Department systems such as the divisions of social services, facility services and public health and other external key informants and stakeholder systems will be consulted on an as-needed basis by this group. The principles of system reform will guide this group's work.

### ***2. Re-organization***

**Objective:** To array Division resources in a manner that supports local management of system resources and away from an institutional focus.

The Division reorganization, included in this Plan, will be fully implemented by January 2003 to coincide with delivery of the first components of the local business plans. Division function will reflect two critical changes:

- (a) Integration of State Plan activities into the formal organization.
- (b) A shift from an intensive, prescriptive relationship with local systems to a relationship that is based on a more supportive and oversight role related to expectations of systems performance.

The Division will model the achievement of efficiencies by adjusting its size commensurate with changes in its approach and responsibilities.

Item (b) is related to the ultimate strategic intent that the state is interested in financing systems performance as opposed to fee reimbursement for expenditure-based services and functions.

### ***3. LME cost model***

**Objective:** The LME cost modeling project will be completed and produce critical information regarding best practice protocols related to LME functions, core functions and market-based cost estimates for these practices.

The intent of the LME cost model is to assure sufficient economies of scale and scope, such as population and size expectations, and to build LME budgets based on a clear delineation from provider responsibilities, such as those related to direct service program management and agency administration. In terms of financing, the Department has made it clear that LME functions must be

paid for within *existing resources*. This is obtainable, as the state will only purchase LME functions that are within the scope of the cost model.

Each LME must make efficient choices regarding whether it ought to *make* the infrastructure necessary to meet defined LME responsibilities, or whether it ought to *buy* some of this functionality either from the private market or from each other.

It will be imperative for the LMEs to employ or purchase these functions in an exemplary manner, as the state will not subsidize costs associated with inefficiency. Current administrative costs reflect the fee-for-service model, current cost-based reimbursement mechanisms and are largely unrelated to quality. There are both historical inefficiencies and some competency issues. *Existing resources* will therefore come from changing the way current area program administrative resources are utilized and by building in budget assumptions that reflect competency and efficiency (i.e., quality). In fact, with all requirements of the model met, LME functions will be more efficient in comparison to those area programs currently expend on administration.

#### **4. Market cost model**

**Objective:** Rate setting methods will change to better align resources and move away from cost-finding and settlement focus toward a more market-oriented approach.

Current rate setting is based on cost-finding methods and negotiations between provider organizations (including area programs) and the state. Some of this effort equates to current expenditure-based budgeting methods in a system that can be described as a *quasi-market* at best. Similar to the LME cost modeling project, determining new ways to identify and contain costs associated with supports, services, treatment and care (including the related program management and administration costs) will be developed. These new reimbursement models need to reflect a system in which services are delivered increasingly through private entities. Costs developed in this state should be compared to costs experienced nationally, taking into account critical variables (e.g., population, urban/rural mix, cost of living, similarity of service definitions and provider qualifications). The result should reflect a more neutral and *non-interested* market range for supports, services, treatment and care. Costs and rates should be reflected in the Medicaid component of the financial strategy in a manner that optimizes the use of federal financial participation.

This effort is related to the ultimate finance strategy intent of: (a) expectations of exemplary provider systems performance; (b) clearly identifying and justifying indirect costs of provider systems and (c) increasing the availability of funds for direct supports, services, treatment and care.

#### **5. Funding fairness**

**Objective:** A distribution plan will be developed that will reflect: (a) consideration of all essential variables necessary to accommodate variations in communities and (b) phase-in plan to mitigate adverse effects of re-distribution.

Current allocations of state funds have been described as lacking any logical fairness in distribution. Equity and consistency are core values of system reform. A distribution plan will be developed that will reflect consideration of all variables necessary to accommodate variations in communities and will include a phase-in plan to mitigate adverse effects of re-distribution.

This effort is related to the ultimate intent of finance strategy that uses fair methods to promote resource equity across the state.

### ***6. State Medicaid Plan revisions***

**Objective:** Making optimum use of community based Medicaid funded services is a linchpin in the financial strategy.

The Medicaid State Plan will be revised to better reflect support, service, treatment and care expectations of the reform efforts. Careful consideration will be given to recommendations developed and the experiences of other states. Medicaid State Plan revisions will need to be considered as part of the coordinated realignment of funding activities discussed above. Changes in state funding buckets must support the optimized use of Medicaid's Rehabilitation Option and Home and Community Based Waivers.

This effort is related to the ultimate finance strategy intent of ensuring that defined entitled services correspond with best practice and emerging best practice.

### ***7. Regulatory, rule and/or practice modifications***

**Objective:** Reduce unnecessary regulations, rules, monitoring and attendant administrative costs in order to support system reform goals and increase funds available for services and supports.

All current (and any new) regulations, rules and/or practices are being evaluated to determine if they fit and if they are applicable to reform efforts.

It should also be noted that systems might need to identify and request state modifications/elimination of existing regulations, rules and/or practices that promote inefficiencies. Systems should identify these and forward them to the Division for follow-through. The Division has set a goal of reducing by 50% current rules and regulations.

This effort is related to the ultimate finance strategy intent of: (a) expectations of regulations, rules and/or practices to promote systems efficiency in public accountability; (b) clearly identifying and justifying indirect costs of regulatory practices; and (c) increasing the availability of funds for direct supports, services, treatment and care.

### ***8. CAP-MR/DD Waiver redesign and development***

**Objective:** To increase federal funds supporting services for individuals with developmental disabilities already being served in the system and creating state and county savings to be redirected to system reform goals.

The CAP-MR/DD Waiver is currently being re-written. The particular emphasis of the redesign is threefold: (a) developing service bands that reflect severity of need; (b) compatibility with the development of person-centered plan oriented and consumer controlled support budgets and (c) ultimate relative fit with the new CMS Independence Waiver (for future transition).

There are a number of individuals currently being served who qualify for CAP MR/DD services and who may be receiving some state Medicaid plan services with the remainder of the cost of services being subsidized by state funds. Individuals residing in DDA homes are examples. In order to ensure the best response to the needs of these individuals and optimize full legitimate federal participation, a number of these individuals should be enrolled in the CAP MR/DD program. Furthermore, as a result of any state funds that become available as a result of these enrollment efforts (net savings after the application of federal revenues), individuals on the waiting list for CAP MR/DD services should also be enrolled (with the net savings applied as the match requirements).

This effort is related to the immediate budget crisis by securing legitimate federal Medicaid match funds for people who could be served by the CAP MR/DD program who are potentially supported, in part, by state dollars only. This effort is related to the ultimate finance strategy, as it is intended to optimize legitimate federal participation as a revenue source.

This effort is also related to the ultimate finance strategy intent of ensuring that defined entitled optional services correspond with best practice and emerging best practice, particularly as related to consumer control and responsibility in purchase of supports and services.

### **9. Integrated Payment and Reporting System (IPRS) Roll Out**

**Objective:** To implement a successful roll out of the IPRS system, as evidenced by cash flow of 95 percent of *clean* claims within a 30-day turnaround for area programs.

The IPRS system is intended to provide LMEs with a data and claims payment infrastructure that aligns reporting and payment with state-intended financing and policy, including targeted populations and services, supports, treatment and care. It is also a platform for claims processing that can apply to the overall future strategy. SFY 02-03 offers a *test year* to best ensure systems performance for future years.

This effort will provide person-specific financially related support for serving people identified as the most critical.

### **10. Medicaid eligibility**

**Objective:** To optimize federal dollars through targeted changes in eligibility, increased eligible identification, redirecting state/county maintenance of effort toward community based services reflecting system reform goals.

In comparison to national averages, the number of enrolled Medicaid beneficiaries with disabilities in North Carolina is low. The current system denies North Carolina its full share of federal financial

participation by leaving people who are not potentially eligible, un-enrolled and by not covering all of the community-based services essential to avoiding over-utilization of institutional care and increasingly non-Medicaid reimbursable care. There has not been an aggressive effort to secure Medicaid enrollment of people we support and serve. This is one of the critical functions of care coordination and case management — assuring that an individual secures all of the benefits and resources they are entitled. Additionally, failure to secure Medicaid benefits will simply find unnecessary state and local subsidization of support, services, treatment and care, particularly using state funds.

Although we may not increase overall state and county share of Medicaid funding liability, we must grow components of the Medicaid budget when they legitimately support system reform and can be at least partially offset by savings in institutional and trans-institutional care. This is known as *optimizing Medicaid*. There are two ways to do this. First, the Medicaid State Plan and Home and Community Based Waiver revisions must reflect less restrictive approaches to Medicaid eligibility for individuals in the target populations. Second, the services eligible for federal reimbursement must support system reform objectives of consumer-driven; recovery, outcomes and performance-oriented and community based services. In order to achieve this end, state funds, including institutional dollars and county maintenance of effort, financing not being used as Medicaid match should be re-directed to support costs associated with Medicaid enrollments of people currently supported and served. This process would also be extended to an increase in Medicaid beneficiaries resulting from a more aggressive enrollment of people entering the system.

This effort is related to the immediate budget crisis by securing legitimate federal Medicaid match funds for people currently and in the future who are supported by state only dollars. This effort is related to the ultimate finance strategy in that it is intended to optimize legitimate federal participation as a revenue source. Additionally, state funds that become available resulting from federal revenues replacing 100 percent state support would be re-directed to support persons in the target/priority population who are not Medicaid eligible.

### **11. Coordination of benefits**

**Objective:** To develop the infrastructure and reporting capabilities to ensure local programs can capture and track 3<sup>rd</sup> party billings.

An emphasis will be placed on securing and appropriately applying all first and third private party revenues. This includes implications, as applicable, of the obligations of providers to accept an insurer's payment as payment in full and of applying collections against the net reimbursement sought from public finance sources.

This effort is related to the immediate budget crisis in that it ensures that private reimbursements are fully captured and applied to mitigate public subsidization. This effort is related to the ultimate finance strategy in that it is intended to optimize all legitimate private funding resources as revenue



sources. Public funds that become available as a result of this process would be re-directed to provide direct funding for needed supports, services, treatment and care.

## **12. Community Placement**

**Objective:** To successfully transition institutionalized individuals to their home communities, per the Olmstead plan, with an associated movement of institutional dollars to the community to support these individuals.

The State of North Carolina has a large number of individuals with mental illness and individuals with developmental disabilities residing in state-operated facilities. Along with the public policy concerns about the need for people to be a part of their natural communities, the funds associated with these institutional arrangements are resources that are in high, fixed-cost programs.

As part of Olmstead planning, and in conjunction with the bridge funds provided in the Mental Health Fund Trust (MHFT), area programs have been responsible for developing community placement plans. In order to move these along efficiently, each area program needs to make these plans final and implement them. It should be noted that area programs should be moving toward using private systems to provide these supports, services, treatment and care. Medicaid State Plan changes and Home and Community Based Waiver redesign must support these efforts.

In completing this process, each area program will negotiate a state net funding amount to be transferred from state institutions to the area program budget. This would include start-up financing (which could include MHTF dollars) and SFY 02-03 phase-in and SFY 03-04 full year state net costs necessary for area program and state-operated program planning. Revenue-side planning will include all resources to be used to support expenditure plans. Medicaid match requirements will be satisfied through application of the net state funds transferred and county maintenance of effort funds that are not being used as Medicaid match. In the event that there are no county funds available, the state net match can be used as the full required match obligation, where sufficient.

The net state financing transfer cannot be dollar for dollar, since it often costs more per bed day to operate facilities with lower occupancy rates. The actual amount of this differential, however, will be smaller as the facilities begin to achieve larger reductions in capacity. However, if all area programs move forward in making their plans final, the negotiation process will be able to take into account the cumulative effect of all area program plans. That is, more rapid downsizing can occur through such things as closure of units, rather than simply leaving a few beds empty on units otherwise being operated. As appropriate, the more people who are able to move into the community, the greater the available proportion of transfer. At the same time, if the Medicaid strategy optimizes federal financial participation (FFP) for community services, some of the transfer differential can be offset by increased availability of FFP for community services.

This process includes the ability to move funds into the community that exceed the needs of the people actually moving (with an understanding that once bed days are reduced to an agreed upon

level, any use over that level would be at the LME's expense). Reimbursements are included in planning revenue in addition to the net state funds involved in the transfer. It is not uncommon, particularly with psychiatric hospitals, that given the nature of financing state-operated systems (intensity of state funds), the state funds involved in the transfer are sufficient to meet unmet needs, community demand and to build community capacity necessary to provide alternatives to state inpatient services. This is especially true when the Medicaid strategy is designed to optimize the use of FFP.

Planning for people with developmental disabilities will include use of CAP-MR/DD slots as preferred over new ICF-MR development. This includes community *move through* efforts such as current ICF-MR residents' transfer to CAP-MR/DD supported arrangements and community placements into existing ICF-MR beds.

This effort is related to the immediate budget crisis in that it ensures that state funds are moved to support people currently residing in state operated institutions with any funding benefits being applied to expanded community capacity (mechanisms to prevent institutionalization of current and future community clients, applied to prevent reductions in support, services, treatment and care, as examples). This effort is related to the ultimate finance strategy in that it is intended to optimize the manner in which (and to whom) the community and the state provides supports, services, treatment and care. In addition, this further aligns public financing on the community side.

### **13. Community outreach and alternatives**

**Objective:** To identify mental retardation center outreach services currently being provided and initiate planning for transfer of these services into the private provider network in the LME geographic area, with associated transition of institution funds to the communities to support this core service function.

This area is related differently to people with developmental disabilities and individuals with mental illness.

State mental retardation centers currently provide a substitute for community capacity. The outreach programs provide services, treatment and care to individuals with developmental disabilities residing in communities. Some of these efforts may be redundant because of existing resources in communities and may or may not be coordinated with the full array of community supports, services, treatment and care.

In order to best develop community capacity, each area program should identify MR center outreach services currently being provided and initiate planning for transfer of these services into their private provider network. Planning would include fiscal negotiations with the state similar to those regarding community placement efforts.

State psychiatric hospitals currently provide an array of acute care and crisis services. These are capacities that should exist as part of a community's provider network (community inpatient, crisis stabilization [crisis residential and/or outreach], as examples).

In order to best develop community capacity, each area program should identify their use of state psychiatric hospital acute and crisis services and initiate planning for transfer of these services into their private provider network. Planning would include fiscal negotiations with the state similar to those regarding community placement efforts.

This effort is related to the immediate budget crisis. It ensures that state funds currently used by communities for state-operated institution services could be applied to community capacity-building efforts to keep services, these people and others like them, closer to home. This effort is related to the ultimate finance strategy in that it is intended to optimize the manner and to whom the community and the state provide supports, services, treatment and care. In addition, this further aligns public financing on the community side.

#### ***14. Target/Priority Population***

**Objective:** To establish target populations, a defined service array and the ability to track data to demonstrate shifts in services received consistent with system reform goals.

The establishment of target/priority populations is intended to prevent adverse selection and to ensure that people in greatest need and at greatest risk are served. This will require LMEs to work quickly and closely with their communities and provider systems (including the area program as a provider, where applicable) in order to develop transitions and resources for non-target/priority populations. This also requires LMEs to have competent and efficient access management capacities. The sooner this is initiated, the sooner systems will be able to minimize support, service, treatment and care financing reductions for the target/priority population, including the need to identify and respond to target/priority population individuals not currently served. The Medicaid finance strategy must ensure that target populations can be eligible and community-based services sufficient to prevent unnecessary institutionalization can be financed using federal funds.

This effort is related to the immediate budget crisis by ensuring that reductions in supports, services, treatment and care are not first targeted toward individuals the system should be serving. This effort is related to the ultimate finance strategy in that it is intended to prevent adverse selection.

#### ***15. Innovations in practice***

**Objective:** To establish state direction for the first three key priorities for best practice implementation at the local level.

This objective speaks to support, service, treatment and care practices and administration and management practices. Collaboration efforts among systems with shared responsibilities for individuals and populations and coordination among other systems responsible for providing

general supports, services, treatment and care should also be considered in this effort. Collaboration assures that the local public specialty system is responding to people whose needs are best addressed among systems. *Responding* includes efforts of participation (systems of care, as an example). Coordination is intended to include making sure that responsible systems are in fact responding to shared individuals (school services, as an example).

Best practice and emerging best practices must be identified and implemented among systems to ensure that exemplary outcome oriented models are applied to the people we serve. This will require LMEs to work quickly and closely with their provider systems (including the area program as a current provider, where applicable) in order to develop transitions to innovations in practice. The sooner this is initiated, the sooner systems will be able to ensure that reductions are directed at outdated and inefficient models of practice, while funding is directed at practice innovations.

Systems should identify and request state modifications/elimination of existing regulations, rules and/or practices that promote inefficiencies. Systems should identify these and forward them to the Division for follow-through.

This effort is related to the immediate budget crisis by ensuring that innovations in practice are first applied in an effort to minimize reductions in supports, services, treatment and care, and to ensure that administrative and management efficiencies are pursued to create indirect savings that could be earmarked for funding reductions. This effort is related to the ultimate finance strategy intent of: (a) expectations of exemplary LME and provider systems performance; (b) clearly identifying and justifying indirect costs of public local management and administration and management costs of provider systems and (c) increasing the availability of funds for direct supports, services, treatment and care, particularly those related to best practice and emerging best practice models.

## **16. Expedited LME development**

**Objective:** To identify location(s) to implement full LME functions in SFY 03-04, including flexible funding.

As is evident in much of this section, there is a natural incentive to expedite the efforts of developing an LME. The current budget crisis clearly requires greater administrative and management efficiencies. Along with organizing strategies to respond to the items described in this section that best promote the development of the LME (developing innovations in practice through the provider system while diminishing outdated and inefficient models of practice the area program currently operates, as an example), other actions including moving forward with consolidations are also necessary. Development of the local business plan within the constraints of the area program will not suffice — the LME is a new and different entity. Given the need to plan with regard to the budget crisis, there would be greater utility in developing the LME as a component of the budget crisis response plan.

This effort is related to the immediate budget crisis by providing an opportunity to design the emerging LME (and dealing with issues of transition) in conjunction with development of a response to the budget crisis (thus, an immediate and future oriented response). This effort is related to the ultimate finance strategy intent of: (a) expectations of exemplary LME systems performance; (b) clearly identifying and justifying indirect costs of public local management and (c) increasing the availability of funds for direct supports, services, treatment and care.

## **SUMMARY: BUILDING THE FUTURE ENVISIONED IN SYSTEM REFORM**

### **SFY 02/03: Foundation building**

As is evident, SFY 02-03 provides the state and local, public and private systems an opportunity to demonstrate competencies required in the evolving State Plan. As difficult as it is, the current state budget crisis provides a live and real time challenge for systems to demonstrate how they can manage most efficiently and creatively. Given that future budget growth will most likely be slow and limited at best, courageous leadership and competent management will be a mainstay in the evolving system. This also provides exemplary systems — in this state and across the country — currently not involved in North Carolina to consider options to enter these efforts and compete and/or replace systems that will exit or not adequately respond to unmet challenges.

During SFY 02-03 the state will develop products that more clearly define the expectations and parameters of the evolving system. Furthermore, efforts by the systems during this difficult budget year and initial full reform planning year will allow for an evaluation of who is ready and who is not.

### **SFY 03/04: Pilot innovations and systems development**

During SFY 02/03, the emerging LMEs will be completing their local business plans for submission in January and April 2003. Emerging LMEs in the first phase will be provided opportunities to negotiate pilot components of LME functions. These pilot components will provide opportunities to move practice beyond the essential parameters of the LME as described in the State Plan.

It has been acknowledged that the State Plan LME model has *practical* and *political margins*. *Practical margins* are built in as legitimate precautions regarding competencies to fully and comprehensively perform core functions. *Political margins* are built in to satisfy real and/or perceived concerns of systems stakeholders. Sometimes it is difficult to distinguish the difference between these two types of margins. However, with every margin, there is a cost. It is expected that there will be some controlled pilots that will have minimal margins built into the LME model. There is a need to test the full and comprehensive LME model for future dissemination.

In terms of financing, there will be efforts to begin to blend funding sources. The state currently operates in a *funding silo matrix*. That is, funding services/supports to disability groups by categorized funding streams. This creates a type of split that limits ability to plan globally, as the system is restricted to planning within small funding *buckets*. Ultimately, there is a need to optimize these funding streams through a process of blending them as much as possible.

During SFY 02-03, and particularly regarding the first phase of emerging LMEs, state statutory and regulatory changes will be carefully explored in an effort to eliminate silos. In addition, federal regulations will also be carefully examined and waivers may be pursued in order to pilot innovations in financing. Furthermore, an incentive/disincentive-financing scheme related to the use of state-operated services would be carefully explored, including a pilot with some of the first phase of emerging LMEs. Systems practices regarding past use of state-operated services will be considered in order to ensure that positive past practices and continuing these practices are sufficiently rewarded. This reward system will be applied in a manner to make sure that consumers are not *punished* for poor systems performance.

#### **SFY 04/05 through 06-07: Model advancements**

With proper evaluation of pilot innovations, knowledge of what was learned will become available during SFY 03-04. There will be wider application SFY 04-05 through 06-07. This will ultimately require substantial changes to the State Medicaid Plan (and waivers) and state financing statutes and regulations necessary for statewide application. Additionally, throughout SFY 02-03 through 06-07, we will be examining developments in other states to explore additional knowledge for potential application to North Carolina.

### **STATE STRATEGIC BUSINESS PLAN**

The State Plan implementation document and the state business plan timeline, included in the first version of the State Plan, have been largely re-worked and combined together into the state strategic business plan. Strategic planning and execution at the state level encompasses a wide array of activities necessary in the transition from old to new. *State Plan 2002: Blueprint for Change* is the state's business plan for reforming the state mh/dd/sas system. The new strategic plan outlines responsibilities and tasks of the Division of MH/DD/SAS required to implement reform and a timeline for their completion. The strategic plan incorporates the mission and principles of the State Plan in both its process and outcome, and is designed to compliment and support creation of local business plans.

As the Division moves forward in its reorganization, implementation structure of committees and workgroups and timeframes for completing work products may change. Supplemental bulletins that report on these changes will be issued, included in the quarterly reports to the LOC and posted on the Department web site.



		Intensity of Need				
		1*	2	3*	4	5*
URGENCY OF NEED	<b>URGENT</b> Examples Service/Support Need Immediate Imminent Danger of: <input type="checkbox"/> Homelessness <input type="checkbox"/> Interface with Justice System <input type="checkbox"/> Institutionalization Medical/Psychiatric Emergency Death of Primary Caregiver Living in unsafe environment					
	<b>CRITICAL</b> Examples: Will need services/supports within 12 months <input type="checkbox"/> Aging Caregiver <input type="checkbox"/> Facing major life transition <input type="checkbox"/> On Waiting List X amount of time and requires service					
	<b>WAITING/PLANNING</b> Examples: Not expected to need services/supports within the next year <input type="checkbox"/> May need more or different services <input type="checkbox"/> Life transition being planned for but not imminent <input type="checkbox"/> On Waiting List					